HOW. E.JONES 04 - 1998DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 10e f 19b per inf 9840 2-22-05 vt. State of Maryland / Department of Health and Mental Hygiene 0 1

09501 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day MARCH 21,2004 **Physician** Howard Edward Jones 2:46p /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SAINT MARY'S HOSPITAL LEONARDTOWN ST. MARY"S If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∕**2 M 2 □ F 217-78-0896 40 Director 17,1964 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Whitemarsh 10f. Zip Code 21162 10g, Citizen of What Country? 10e. Street and Number **Allender** 23a or 5709 Allender-Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11 Marital Status 1 □ Yes 2 ② No If Yes, Give Year or Dates: 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient important: if item 27 is marked other that any injury or other traumaric 12 Years Mechanic Automobile 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be J Wynne Jones Madeline Greenbeck 19b. Mailing Addres Astra Quality or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5709 A. Allenden Road Whitemarsh, Maryland 21262 Theresa Jones Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cem. 3/26/2004 Rosedale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** HYPERTENSIVE ATHEROSCIEROTIC (ARDIOVASULAR resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Divi to für as a consequence of Examiner burial-transit and Due to (or as a consequence of) P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Qnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an autopsy performe 1 XYes 2 □ No or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) XYes 2 No 2XX €R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) **OCME** MARCH 22,2004 Ques 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RNB10 MP 111 Penn Street, Baltimore, Maryland 21201

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

32. Registrar's Signature

2004 9

			1- For State of Maryland / Dep Ce	artment of Health and I	Mental Hygie	211116	09502
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
A	/Medio	al	Joseph A. Janecek 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		23, 2004 4c. County of Death	9:30 P M
	LXdIIIII	eı	Heritage Nursing Home	N/A		Balti	
c	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 12 - 05 - 9230 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 23,	9. Birth Cou 1915 N	place (State or Foreign intry) WYLAND
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show	to	Maryland Baltimore	Dundalk			1 Tyes 2 No
	or 28s	Director	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Cou	untry?
	s 23a		1721 Brookview Road	21222		U. S. A.	
20		by Funeral	1 ⚠ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 No Specify:	pecity Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
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and	0 =	BeC	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	iden Sumame)	
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Mar	s 1 and 2 sh f Health and ftem 27 la m other traum			ling Address (Street and Number or Ru I Brookview Road,			
ē,	es 1 ar of Heal fitem 3 r other		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)		c. Location - City or T	
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Dan	permit. Pag Deportment Importent: any injury o		21. Signature of Funeral Service-Linensee	22. Name and Address of Facility Sc 3331 Brehms Lane,	himunek Fi Baltimore,	uneral Hon , Maryland	nes d 21213
	Physician		23a. Pant Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	iter the mode of dying, such as cardiac	or respiratory arrest,	N	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	NI HUDE	2-1	CLAL	LIVENDS
ı		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	TL 11 (7 L)	CHU	SION	16 THE
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8/60,	be exesician a		resulting in death) Last Due to (or as a consequence of):				
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C. BOX	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delik Month	very Day Year
ds, r	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the CNON HEALING ULCER	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
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UIVISION	or Attan after deal Director in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Stree City or Town, S	it and Number or Rui State)	al Route Number,
_	To the Hospitel or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one) A medical Examiner: On the bass of examination and/or in and manner stated.	th occurred at the time, date and place	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title officeration	29c, License number	29d.	Date signed (Month,	Day, Year)
	6		30. Name and address of morshin who completed chargest doctor (Bar) 233) Type	500 910-A RIT	CHIE	HIGHW	Ay,
)		THE BALL	MORE, MAR	YLAND	212	25.
	Sta Registi		31. Date liled (Month, Day, Year) MAR 2 9 2004 32. egistrar's Signatur		(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev Year **Physician** Jones Frieda Virginia 23 752 Am IARCH 2004 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Hospital Stella Maris Hospice Baltimore If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Social Security Number 7. Age (In yrs. lest birthday) Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2XX 81 Director 217-16-0873 02 MD Usuel Residence of Decedent filed within 72 hours after death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23e or 28e-f ehov ner nwat be notified at X Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 613 Mount Holly Street 21229 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes XIXNo If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 Mo Specify: Black Specify: ð XIXWidowed 4 ☐ Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker llth grade na Own Home ith end Mental Hygie 27 Is marked other r traumatic event, parmit. Peges 1 and 2 should be file Department of Haalth end Mental Hy, Important: If Ihem 27 is marked any Injury or need to be any Injury or ne 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Mildred Burnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clark N. Jones-Son 2714 West Franklin Street, Baltimore Md 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 3/27/04 Pikesville, Md 22. Name and Address of Facility
March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore Md Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner or Attending Physician: The law requiras that tha death certificate ba axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of) Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24a. Was en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1. Yes 24No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director: After this cay filled in by the funerel dire 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 3/23/2004 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) berg 31. Date filed (Month, Day, Year) 32. Registrer's Signature State MAR Z 9 2004 Registrar

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760

Jones, FriedA

		For State of Maryland / Department of Health and Mo 1 - State Pregistrer Certificate of Death	Reg.	2004	0950
Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death	Day Year	3. Time of Death
/Medica	al	HERBERT RUSSEL KARLE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	MARCH	26 2004 4c. County of Death	TOAI
Examine	er	GOOD SAMARITAN HOSPITAL BALTIMORE		to. Godiny of Bodan	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Ye	9. Birthy 92 PG	place (State or Foreintry) NNSYLVAN
yland		10a. State 10b. County 10c. City, Town or Location			0d. Inside City Limi
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death with the Maryland ms 23e or 28a-f show finust be nutilied at	ai Director	10e. Street and Number 10f. Zip Code 2705 BURRIDGE ROAD 21234	10g.	Citizen of What Coul	ntry?
5 2	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto File Planck Control of File Planck Co	cify Yes or No- lican, etc.)	14. Race - Americ Black, White,	ean Indian, etc.
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Maryiand 21215-0036 d 2 should be filed within 72 hours at tith and Mental Hygiene. Z is marked other than "natural, or traumatic event, Ire Madical Exami	To Be	17. Father's Name (First, Middle, Last) CHARLES R. KARLE 18. Mother's Name JESSI	E M. 1	HILTNER	-
Mar d 2 sh th and th and 7 ls m traum		19a. Informant's Name/Relationship (Type, Print) THELMA NARLE WIFE 2705 BURRIDGE ROM		ty or Town, State, Zip MORE, MI	
s 1 and 1 Heal		20a. Method of Disposition 20b. Place of Disposition (Name of Dispositio		Location - City or To	
Saltimore, bernit. Pages 1 ar Department of Hea mportant: If Item 2 nny injury or other		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)	12004 P	ARKVILLE	MARYIAL
Salti Permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	NS CHAP	EL OF ME	NORIES
0 82558		8800 HARFORD RO		WILLE MI	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) SEPSIS			Onsor and Death
Examiner		Due to (or as a consequence of):			
	Je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
cuted nd ransit	Examiner	cause. Enter Underlying Cause Underlying			
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BOX Beath certi	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown 9 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 9 Unknown		23d. Date of delive Month	ery Day Year
uires that the de signed by the a	Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
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w requir	iete	MYOCARDIAL INFARCTION	24a. Was an	24b. Were auto	psy findings availa
r VI(al Hee) yaician: The lav is certilicate has director, page 2	mo		autopsy performed 1 ☐ Yes 2 🗹	death?	mpletion of cause ∈ 2□ No
VICAL P	Be C	25. Was case referred to medical acaminer?		_	
OT V Phyaic this ce al dire	ို	1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom		6 ☐Other (Specif	y)
UNISION OF VITAL RECORDS, P.O. To the Hospital or Attanding Phyaicien: The law requires that the diwithin 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Certification;	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	3d. Describe how in		
UIVI:	Certifi	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Bf. Location (Street City or Town, St	t and Number or Rura tate)	il Route Number,
the Hospital or hin 24 hours afte the Funeral Dir npletely filled in	Medical	29a. Certifier (Check only one) **Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, are 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number RES 000		Date signed (Month,	
21		Saile Chankar		RLH 26	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUTI SHANKAR, 5601 LOCH RAYEN BLVD, BA	4LTIMO	RE, MD-	21239
10,					
10,1	to-				
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 9 2004 ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Year William Linzey, Sr. March 22, Ernest 2004 1:18 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) Towson Baltimore Greater Baltimore Medical Ctr. If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months Hours 1 XM 2 ☐ F Yrs. Director Maryland 219-38-3343 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 28s-f ahow item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinan must be notified at 1 Yes 25No Director Maryland Baltimore Eastpoint 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 United States 8054 Bank Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed by Vietnam White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withi nent of Health and Mental Hygiene. int: if item 27 ia marksd other than 10 Years Ironworker Local 16 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Joseph Linzey Eleanor V. Cline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan M. Linzey /Wife 8054 Bank Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or otl
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery 3/25/2004 * 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Failure egy inatur **Physician** 3WEEKS /Medical (o) as a consequence of): Examiner cramous (41 Metastatuc Cancinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and thed for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, nain Yes 3 Probably 4 Unknown 2 No Completed 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer Yes 276 page certificate 1 ☐ Yes 2 ☐ No 1 Yes Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 NO 1 Yes Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 27. Manner of Death

Natural

Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending Injury after death. 1 Tes 2 No investigation М the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral I the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sig State

DHMH 17 Rev 1/2001

Registrar

			For State						Mental Hyg	giene leg. No. 200	L 09507
			1 - State Registrar AMEND TTEM 1. Decedent's Name (First, Midd	ie, Last)			inoato or	<u> </u>	2. Date of Dea	ith No.	3. Time of Death
* 3	Physici /Medic			atherine		ď	4h Cihi Tana	r Location of Deat	March	25, 2004 dc. County of De	1:35aM
	Examin	er	4a. Facility Name (If not institution 2344 Old New	-				indsor	(1)	Carı	
Y	Funeral Director		5. Social Security Number 219–18–7470	6. Sex 1 ☐ M 2 1 F	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		21°, 1925	irthptace (State or Foreign NaTYLand
	and		Usual Residence of Decedent 10a. State 10b. County	,	10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	e-feho	ctor	Md. Balt	imore		Upperc	0				1 Yes 2 No
	h with the 23a or 28	ai Director	10e. Street and Number 5006 F.	rye Rd.			10f. Zip Code 211	55	1	10g. Citizen of What (•
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or itams 23a or 28a-f ehow empty injury or other traumatic event, it a Medical Exaction could be notified at ances.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorce	ried Armed F	2.♣ No live	, t	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	Black, Wh	
2	72 ho	eted		nt's Education est grade completed	יי	16a. Deced	dent's Usuat Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Kind of Busines	s/industry
7	within iene. r then	Completed	Elementary/Secondary (0-12)	College	(1-4or 5+)		oof Read			Printin	g Company
pu	al Hyg	Be C	17. Father's Name (First, Middle	,					me (First, Middle,		· ·
Maryland 21215-0036	should Ind Meni	ဥ	Robert Jo	oseph S c ho	ollian	19b Mailir	ng Address (Street		ine Marie	Hardy r, City or Town, State	Zip Code)
	1 and 2 s Health an Iem 27 is		Charles Lankfor						apolis, M	•	
Baltimore,	Pages 1 and the part: If them ant: If them arry or other		20a. Method of Disposition 1 ABurial 2 Cremation 4 Donation 5 Other (n State	cemetery, crer	sition (Name of matory or other place Mem. Par			20c. Location - City of Sykesvil.	
Balt	permit. Page Department of Importent: If eny injury or 2002.		21. Signature of Funeral Service	bland 1			Eckhardt	Funeral	Chapel,	P.A.	ls, Md. 21117
	Physician /Medical Examiner		23a. Part 1. Enter the disease, c shock, or heart failure. Lis timediate Cause (Final disease or condition resulting in death) Sequentially list conditions	a. Ch	each line.	th. Do not ent		g, such as cardia	c or respiratory arr		Approximate Interval Between Onset and Death
,8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	o (or as a consec						
P.O. Box 6	that the death certificed by the attending properties as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	1 Live	utcome of pregn birth 2 Fet gnant at time of a nown	al death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
rds, P.	quires that n signed b uld be deta	d by Pt	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part I.		~ /	to the cause of death? Probably 4 Unknown
Vital Records,		Completed	1						24a. Was a autops perfor	sy prior to	
Vit	rsician: Th s certificate lirector, pag	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 🕱 No	Hospital:	Inpatient 2] ER/Outpatier	nt 3 DOA Oth	er	ath <i>(Check only or</i> Home 15⊈Re sid		SON's
Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	ation: T	27. Manner of Death 1 Natural 5 Pend 2 Accident invest	28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	f 28c. Injur Wor	v at	1	ow injury occurred	RESIDENCE
Divis	tal or Atta s after de af Diracto ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 289. Place	ce of Injury - At h ding, etc. <i>(Spec</i>	nome, farm, str ufy)	reel, factory, office		28f. Location (S City or Town	itreet and Number or I n, State)	Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in It	Medicai	29a. Certifier Certify (Check only 2 Medica	Examiner: On the	ne best of my kn basis of examin inner stated.	owledge, deatl ation and/or in	h occurred at the tir vestigation, in my o	ne, date and place pinion, death occ	e, and due to the c urred at the time, d	ause(s) and manner a date and place, and di	as stated. ue to the cause(s)
•	To t withi To tl	Σ	29b. Signature and title of certifit	Robert 1	no		29c. Licens	e number		March 25	
	0	1	30. Name and address of person Carroll Med. C	mers 423	IN. We	ods Tre	Print)			*******************************	
	Sta Regist		31. Date filed (Month, Day, Year MAR 2 9	2004	Registrar's Sign	ature	ste '				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Maryla	,	partment of F ertificate of a			ene 200	4 09508
	ysicia Medic	ın	Decedent's Name (First, Middle, Las	t)		LubA	esky	2. Date of Death Month MARCH	Day Year 24, 2004	3. Time of Death 6:15 PM
E: Fur	camin neral	er	4a. Facility Name (If not institution, give 5. Social Security Number 6. Security Number 11.	OKINS HOSON T. Ago (In yrs	s. last birthda	BAH:	I Under 24 Hrs Hours Min	8. Date of Birth	4c. County of Death 9. Birth County 1943 KAZ	N/A pplece (State or Foreign untry)
- g	ctor		Usuel Residence of Decedent 10a. State 10b. County		City, Town or	Location		AUG.15,	1943 KAZ	AKHSTAN 10d. Inside City Limits
the Maryl	notified a	Director	MD BALT	IMORE	BAI	LTIMORE		100	g. Citizen of What Co	1 Tyes 2 No
io after death with the Maryland or Iteme 23a or 28a-f show	other traumatic event, if a Medical Examiner must be notified at	Funeral	6-B FOURWOOD COU 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	U.S. 13	3. Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	, etc.
within 72 hours at the "patural" or	Medical Exa	Completed by	3 X Widowed 4 □ Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Gi life	1 Yes 2 No cedent's Usual Occup ve kind of work done . DO NOT use retired	during most of we	orking	Specify: Bb. Kind of Business/I	,
IZNO ZI	event, Its	Be	17. Father's Name (First, Middle, Last) LEONID	746	F LII GRANICI	NGUIST	18. Mother's Na	ime (First, Middle, Ma		TRICH
Maryian od 2 should be th and Mental	traumatic	ဥ	19a. Informant's Name/Relationship (7	Type, Print)	19b. Ma	iling Address (Street	and Number or F	lural Route Number, (City or Town, State, Z	ip Code)
More, Peges 1 ar	ry or other		20a. Method of Disposition 1 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify	Removal from State	Place of Dis	position (Name of rematory or other place	ce)		Dc. Location - City or T	Town, State
Department of Important of Impo	any inju 2008		21. Signature of Funeral Service Licen			22. Name and Addre	ss of Facility	OL LEVINS	ON & BROS. IKESVILLE,	, INC.
Physi /Med Exam	dical		23a. Part1. Enter the disease, or come shock, or hear failure. List only limmediate Cause Final disease or condition resulting in death)	plications that caused the de one cause on each line. a. Due to (or as a lonse	OMA	enter the mode of dyin	ng, such as cardia	ac or respiratory arres	it,	Approximate Interval Between On, et and Death
cate be executed	burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	b. Due to (or as a conse						
.O. BOX 68/ the death certificate	stached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \subseteq \subseteq \subseteq \subseteq \no \) 9 \(\subseteq \subseteq \no	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death	3 □Ectopic pregnancy 5 □ Other (specify) _	y		23d. Date of deliment	very Day Year
- 5 3	op ec	þ	Part II. Other significant conditions o	ontributing to death but not re	esulting in the	underlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
The la	, page 2 should I	Completed						24a. Was an autopsy performe	prior to c death?	topsy findings available completion of cause of
Of VITA Physician	rat director, pag	: To Be	25. Was case referred to medical examiner? 1 Yes 2 60	Hospital: 1 Impatient 2 28a. Date of Injury	ER/Outpat	Herit 30 DOA	ner: 4 🗆 Nursing	Home 5 Residen 28d. Describe how	ce 6 Other (Spec	ify)
C Gui	d in by the funer	Certification:	1	(Month, Day Year)	Injur	y Woi	rk? Yes 2 □ No		et and Number or Ru	ral Route Number,
Hospital 24 hours	completely filled in	edical Ce	29a. Certifier 1 Cartifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my k ninar: On the basis of exami and manner stated.	nowledge, de ination and/or	eath occurred at the tir r investigation, in my o	me, date and place	ce, and due to the cau	use(s) and manner as e and place, and due	stated. to the cause(s)
To the	СОШО	Me	29b. Signature and title of certifier	in		29c. Licens	-000	n	d. Date signed (Month	Day, Year) 4, 2004
\	0		30. Name and address of person who ZEEBA MATHEL 31. Date filed (Month, Day, Year)	completed cause of death (It	WOIFE	se. Print)	BAH	ugez, M.	reyland 2	21287
≪∜ R	Sta legisti			2 9 2004	Sener	~ B	Sparks	/ -		

		1	For State Registrar	State of Maryland		artment of H			giene Reg. No. 2 (004	09509
			1. Decedent's Name (First, Middle, Las					2. Date of Dea Month	Day	Yeer	3. Time of Death
	Physicia /Medic	al	Kadn Mutt			th City Town or	Location of Dog	March	-	004 by of Death	06:05 R M
	Examin	er	4a. Facility Name (If not institution, give	Mand medical	TUNK	4b. City, Town, or	MUVE.		40. 00011	y or boats	
	Funeral Director		5. Social Security Number 6. Se	-		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y, Year) ,1931	9. Birthe Cour Tur	olace (State or Foreign http) key
	pur *		Usuel Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation				1	10d. Inside City Limits
	Maryla 1 • ho	tor	MD Anne Aru	ndel Anna	polis						1 X Yes 2 No
	or 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?
	ath wi	rai		lands Drive 12. Was Decedent Ever in U.S	12	214		Specify Yes or No	US.	A ace - Americ	can Indian,
336	72 hours after death with the Maryland "natural", or Items 23a or 28a-f ehow olical Examinational by notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 XNo	Specify:	nto Rican, etc.)	Spec	ack, White, ify: Wh	etc. ite
2-0	72 hou	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	(Give	dent's Usual Occup- kind of work done	during most of w	orking	16b. Kind of	3usiness/In	dustry
121	within 7. Jene. r than "n	mpl	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		<i>DO NOT use retired</i> hiatrist	"		Medi	cine	
Maryland 21215-0036	be filed stal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Celal	Mutlu			18. Mother's Na Saadet	ame (First, Middle	Maiden Suma	me)	
Mary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic ev	F	19a. Informant's Name/Relationship (Mary Janon Franks	урө, Print) s Daughter	19b. Maili 3058	ng Address <i>(Street</i> Mimon Dri	and Number or F ve Anna	Rural Route Numb polis MD	er, City or Town 21403	n, State, Zij	o Code)
Baltimore,	Pages 1 and 2. ent of Health a. nt: If item 27 is		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specification)	Removal from State Lack	ace of Dispo Emont	osition (Name of matery or other place Cemetery	3-2	Date 8-04	20c. Location Davids		le,MD
Baltii	permit. Pages Department of the Important: If ite any injury or of once.		21. Signature of Funeral Service Licer			2. Name and Addre ardesty F		Home P.A	. 12 Ri	dge1y	21401 Ave ANN MD
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line. a. Gasto in His Due to (or as a consequence)	hnal	ter the mode of dyin	ng, such a <i>s</i> cardi	ac or respiratory a	rre <i>s</i> t,		Approximate Interval Between Onset and Death 25 Nours
5	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ							
,092	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequent	ence of):						
68	certificate Iding physise as the			7							
D. Box	ne death cer the attendin thed for use	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	□Ectopic pregnanc □ Other (specify) _	у			Date of delive Month	very Day Year
ds, P.O.	requires that the death een signed by the atten nould be detached for u	d by Ph	Part II. Dther significent conditions	contributing to death but not resu	ilting in the	underlying cause giv	ven in Part I.		tobacco use co Yes 2 No		the cause of death?
Vital Records,	has has	Completed						24a. Was auto perf 1 \(\text{Yes}	s an 24th ppsy ormed?	death?	copsy findings available completion of cause of 2 No
ital	ician: The certificate ector, pag	BeC	25. Was case referred to medical examiner?					Death Check onl	one		
of V	S S	မ	1 ☐ Yes 2 ☑ No		ER/Outpatie	ent 3 DOA		Home 5 ☐ Res 28d. Describe	how injury occ		ify)
Division (ath. r: After	ation	27. Manuar or Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not 1	(Month, Day Year)	Injury	M 1 =	rk?]Yes 2□No				ral Route Number,
Divis	i Gift	Certification:	3 Suicide 6 Could not 1 4 Homicide determined	building, etc. (Specify	′) 			City or To	own, State)		
	Hospital	Medical	29a. Certifier 1½ Certifying P (Check only one) 2 Medicel Exa	nysician: To the best of my knorminer: On the basis of examinat and manner stated.	wiedge, dea tion and/or	ath occurred at the trinvestigation, in my	me, date and pla opinion, death o	ace, and due to the ccurred at the time	e cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date sig		
	F ≥ F ŏ		I genifica;	auln MD		PIT	1646		Marc	n 29	5,2004
	ý		30. Name and address of person who	10	-		eet	Balton	nove, N	1D	21201
	S Regis	tate	31. Date filed (Month, Day, Year) MAR 2 9 200	32. Registrar's Signa	ture	will a					

DHMH 17 Rev 1/2001

ORIGINAL

			Please			DIE INK. Ensure	•	_
			For State	State of Maryla		ent of Health and	Mental Hygier	1e 2001 00510
_			Registrar		Certific	ate of Death	Reg. f	
	Physici /Medic		1. Decedent's Name (First, Middle, Last Joseph W.	Michel	<i>i</i>		2. Date of Death Month	Day Year 3. Time of Death 7:15A.M
	Examin		4a. Facility Name (If not institution, give	street and number)	4b. C	City, Town, or Location of Deal	th	4c. County of Death Baltomore Co.
6	Funeral Director		5. Social Security Number 6. Se		. last birthday) If Un Monti	nder 1 Year If Under 24 Hrs		9. Birthplace (State or Foreign Country)
			Usual Residence of Decedent 10a. State 10b. County		ity, Town or Location		Dec: 27,	10d. Inside City Limits
	n the Maryland r 28a-f show r collified at	ector	Maryand Baltin	ρ	Saltimor			1 □ Yes 2 No
SAM	23a or 2	rai Dire	3032 Morela	nd Ave.		21239		Citizen of What Country?
+ 9: (° 5-0036	within 72 hours after death with the Maryland ene. then "netural; or Items 23a or 28a-f show the Medical Examinat must be notified at	Completed by Funeral Director	11. Marital Status 1 Never Married AMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1.24 Yes 2 \(\sum \) No (1) If Yes, Give Year or Dates:	62.11	acedent of Hispanic Origin? (S specify Cuban, Mexican, Puer s 20 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-C	filed within 72 h Hygiene. Ither then "natu	ompleted	15. Decedent's Edi (Specify only highest grad		16a. Decedent's L (Give kind of life, DO NO	Usual Occupation work done during most of wo Tuse retired)	rking	Kind of Business/Industry Tenn L. Martins
and 2	e d la	To Be C	17. Father's Name (First, Middle, Last) Francis (5)	michel		1	me (First, Middle, Maid	en Sumame) Vitek
Mary	1 and 2 should be Health and Mental sm 27 is marked of ther traumatic even		19a. Informant's Name/Relationship (T)	ones (Daught	リフィフラ	ress (Street and Number or R. Moreland An	ural Route Number, City	y or Town, State, Zio Code) n 3 re, MD, 21234
A A B	of to		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	20b.	Place of Disposition (cometery, crematory)	or,other place) 🔎 🦼 👔	Date 20c.	Location - City or Town, State Forest MI MD.
Micuell S Baltimor	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Ucens	Dur As	2 Name	and Address of Facility	SHAPE	ZKVIHE, VND, 21234 Approximate
=			23a. P. 11 Pht the disease, or comp shiply or real failure. List only	lcations that caused the deane cause on each line.	ath. Do not enter the n		c or respiratory arrest,	Approximate Interval Between Onset and Death
9	Physician /Medical Examiner		Immediate Cause (Pinal disease or condition resulting in death)	Due to (or as a conse		NEBS	·	years
		iner	if any, leading to immediate cause. Enter Underlying	b. — Sue to (or as a conse	quence of)-			
⊆ 09	be executed sician and burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):			
C 29	cate t			d				
). Box 6	death cert e attending id for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \) No 9 \(\text{Unknown} \)	23c. If yes, outcome of pregr 1□Live birth 2□Fet 4□Pregnant at time of 9□Unknown	al death 3 Ectopia	c pregnancy (specify)		23d. Date of delivery Month Day Year
- A	that the died by the detached	/ Phy	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlyin	ng cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ords,	w requires that been signed t should be det	ted by					1 ☐ Yes	2 No 3 Probably 4 □Unknown
N Recor	he la e has age 2	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital		e e	25. Was case referred to medical			26 Place of De	1 ☐ Yes 2X N	No 1 Yes 2 No
>	ysician: ns certifica director, p	To B	examiner? 1 ☐ Yes 2 Solo	Hospital: 1 Inpatient 2	ER/Outpatient 3□	0.4	lome 5 Residence	6 Eigher (Specify) HOSPICE
i o L	ng Phy Iter thi	on: T	27. Manner of Ceath 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	
Division	Attending I death. ctor: Atter y the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	М	1 Tes 2 No	28f. Location (Street	and Number or Rural Route Number,
D.	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; to		4 Homicide	building, etc. (Spec	ify)		City or Town, Sta	ate)
	n 24 ho n 24 ho ne Fun	edical	(Check-only 2 Medical Exemi	ner: On the basis of examin and manner stated.	ation and/or investigat	red at the time, date and place tion, in my opinion, death occu	rred at the time, date a	(s) and manner as stated. Ind place, and due to the cause(s)
	To the within 2 To the complet	Ě	29b. Signature and title of certifier			29c. License number	29d. 0	Date signed (Month, Day, Year)
	it		Mercant	W S	-00-1/5	X 28203	Mar	ch 28 2004
			30 Namé and address of person who co	es mo 66	or N. Cho	eles St Balty	whe ND	21204
	Sta Registr		31. Date filed (Month Day, Year) 20	32 Registrar's Sign	The American			1

			Amend Items 23a,b,	c,PtII,2	5,27,28	Certific	ate of l	237 11/23 Death	704dhb	Reg. No. 200	4 09511
	0	•	1. Decedent's Name (First, Middle, Lest)						2. Date of Dec	eth Day Year	3. Time of Death
	Physicia /Medic		Carole Anne McCoy						MARCH	22 2004	
	Examin		4a Fecility Neme (If not institution, give stre				4	b. City, Town, or L			ath
			Calvert Manor Heal				nder 1 Year	Rising If Under 24 Hrs.		Cecil	
	Funeral Director		177-34-3403	7. Age	(In yrs. lest birth	rs. Mon		Hours Min.	8. Date of Birt (Month, De May 26,		rthplace (State or Foreign ountry)
	and and		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
3	Mary	ğ	MD Cecil		Risi	ng Sui	ı				1 ves 2 □ No
	1 than 128 t	Director	10e. Street end Number				. Zip Code			10g. Citizen of What C	ountry?
	13 wit		52 Louise Ct.				21911			USA	
	ga a g	Funeral	11. Marital Status 12.	Was Decedent En	ver in U,S.	13. Was D If Yes,	ecedent of H specify Cuba	ispenic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race - Am Black, Wh	
Baltimore, Maryland 21215-0020	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. And other than "naturel", or ferms 23e or 28e-f ehow event, the Madical Examiner must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □ Y €	es 21 No	Specify:		Specify:	White
2-0	72 h	etec	15. Decedent's Educat (Specify only highest grede of		((Give kind o	Usual Occup	during most of work	ing	16b. Kind of Business	s/Industry
2	vithin han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)		OT use retired	0		11 - 041	
2	filad v Hygia ther t	ပိ	17. Father's Neme (First, Middle, Last)	2		LPN No	vise	18. Mother's Nam	e (First, Middle,	Healthca Maiden Surname)	re
an	uld be i Aantal I rked of tic eve	9 Be	Walter E. Kemether					Grace	Phades		
<u> </u>	d 2 should th and Man 7 ie marke traumatic	၉	19a. Informant's Name/Relationship (Type	Print)	19b.	Mailing Add	ress (Street			er, City or Town, State,	Zip Code)
Ž		- 1	Lynda J. White/dau	ahter		565 Le	es Br	idae Road	Notti	ngham, PA	19362
ē,	gas 1 and tof Haal		20a. Method of Disposition		20b. Place of I	Disposition , crematory	(Name of or other place	:e)	Date	20c. Location - City o	
Ë	Trans.		1 Burial 2 □ Cremation 3 □ Rem 4 □ Donation 5 □ Other (Specify)	noval from State	Brooku				3-27-04	Rising S	TLV2
a	parmit. Paga Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		1.	22. Nam	e and Addre	ss of Fecility R.	T. Foar	d Funeral	Home. P.A.
m	8 9 E 2 9	- 4	Kichard L.	Good	ghie					ng Sun, MD	
			23a. Part1 Enter the disease, or complica shock, or heart failure. List only one	tions that caused t	he death. Do no						Approximate Interval Between
1	Physician	П	/		xic Ene						Onset and Death
16	/Medical miner		Immediate Cause (Final disease or condition resulting in death) a.	Kespie	A TOTAL	ATUM	Charity				!
		ner	resulting in dealiny	APOXIC	bable P			bolism	61	7/	1
	ificata ba axac ted g physician and as tha burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		oue to (or es e co			s			
68760,	ba ay ician buria		cause. Enter Underlying Ceuse (Disease or injury that initiated events	DAKHOH		-	VENT		11/6	D BY MEDICAL EXAMINEF	-
587	icata phys	edical	resulting in death) Last	D	ue to (or es e co	onsequence	of):		/ w	BY MEDICAL EXAMINE	
Box	cartil nding usa a		d					AERTIFIC	ATION APPROVEL		1
m	daath a atta d for	icia	Part II. Other significent conditions contril	buting to death but	not resulting in	the underly	ing cause giv	en in Part I.	23b. Did	tobacco use contribu	te to the cause of death?
О	t tha by th tacha	Physician/M				,			10	Yes 2 ² No 3□	Probably 4 🗆 Unknown
s,	gned gned be da	by F	Conorpany An	Teny DIS	PASE					•	
Division of Vital Records,	v raquiras that tha death cartificata ba axac, bean signed by tha attanding physician and should be datached for usa as tha burial-tra	Completed	DIABETES MER	LITUS, R	ight fo	ot di	elocat	ion		an autopsy 24b ormed?	. Were autopsy findings available prior to completion of cause
e O	S S	npie	J. 1, 1000 0	,	15112 10	OL GI	SIOCAL	TOIL	- N.		of death?
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<u> </u>	Physician: The tribic cartificata irat diractor, pag	Be	25. Was case referred to medical examiner?	spital:			Oth	26. Place of Dea			
5		. To	THE THE ZLINE	1 ☐ Inpatier 28a. Date of Injury	7		J DOA	THE NUISING FIL		dence 6 Other (Sp how injury occurred	ecity)
5	ding h. Aftar funa	Certification:	Dending 5 □ Pending	(Month, Dey December	Year) In	jury knowiM	28c. Injur Wor 1 □	k? Yes 2⊠No		vehicle ac	cident
18	Attending tr death. ector: Aftar by the fune	fica		28e. Place of Inju- building, etc.	2000				28f. Location (Street and Number or I	Rural Route Number,
	afta Dire	ert	4 Homicide	Unknown	(Specify)				Unknown		
	To the Hospital or Attending Physwithin & Within Z4 hours after death. To the Funeral Director: After this complately filled in by the funeral d	edicai C	29a. Certifier (Check only one) Certifying Physic 2 Medical Examine	ian: To the best of	examinetion end	death occu Vor investiga	rred et the tir ation, in my o	ne, date end plece, pinion, death occur	and due to the	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)
	the the	Me	29b. Signature and title of certifier	and mainer ster			29c. Licens	e number		29d. Date signed (Mor	nth, Day, Year)
	₹ <u>₹</u> ₹8		Phon				1400	58419		Marich 24.	2004
			30 Neme end address of person who com	pleted cause of de	ath (Item 23e) (Type, Print)					
	10		ROOMEY DONITAM	D.0 18	355L 188	GNUAPE	ROOM	, Rising	SUD, MI	21911	
	Sta ° Registr		31. Dete filed (Month, Day, Yeer) MAR 2 9 2004	32. Registre	r's Signature	Spore	K)				

			State of Marylar	nd / Depart <i>Certii</i>	ment of F ficate of	leaith and M Death		Reg. No.	04	09512
	Physician	1. Decedent's Name (First, Middle, L		*			2. Dete of Dee Month	Dey	Year	3. Time of Death
	/Medical	Frances 4a Facility Neme (If not institutjon, g	Mrozinsk	1		4b. City, Town, or Lo	Cation of Deeth	0/0	of Deeth	830m
	Examiner Funeral Director	LORIEN (a)		root birtingoy/	f Under 1 Year Ionths Days	Bellan	8. Dete of Birth (Month, De) Sept	HA	RFOR	ce (State or Foreign
	D.	Usuel Residence of Decedent	140-0	-						
	show of anyle	Md. Harf		ty, Town or Locati					100	d. Inside City Limits 1 ☐ Yes 2 🖾 No
	28a-1	10e. Street end Number	ord	Bel Ai	L 10f. Zip Code			10g. Citizen of V	Whet Countr	v?
L	oth with the Marylen 23a or 28a-f show ust be notified at rai Director	1208 Constati	ne Court		21014			USA		, ,
(82218 KZ	build be filed within 72 hours after deeth with the Maryland Mantal Hygiene. Inked other than "natural", or items 23s or 28s-f show rite event, the Medical Examinar must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Never Merried 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2≦ No If Yes, Give Year or Dates:		s Decedent of Hes, specify Cuba	fispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Rac Blac Specify	a - American ck, White, etc : Whi	c.
500	72 ho	15. Decedent's (Specify only highest g	Education rede completed)	16e. Deceden	t's Usual Occup	ation during most of workir	ng .	16b. Kind of Bu	ısiness/Indu	stry
25	mple mple	Elementery/Secondary (0-12)	College (1-4or 5+)	Home		during most of workiid)		Oran	Home	
d 2	_ = 0	17. Fether's Neme (First, Middle, Las	st)	Поше	riak	18. Mother's Name	(First. Middle.			
CES Maryland	Mantal Mantal or stic eve		kowiak				Andry		7	
ary	should be and Mante a marked iumatic er	19e. Informant's Name/Relationship	(Type, Print)	19b. Mailing A	Address (Street	and Number or Rure	Route Numbe	r, City or Town,	State, Zip C	code)
_	and 2 salth a 27 is	Martin M. Mro		1208	Const	atine Co	urt Be	el Air	, Md.	21014
Baltimore,	Pages 1 and 2 should be filed nent of Haaith and Mantal Hyg nit; if item 27 is marked other ury or other traumatic event, To Be C	20e. Method of Disposition	Hemoval from State C+	Place of Disposition cometery, cremate • Stant	on <i>(Name of</i> ory or other ple islaus	Cem. 3	/26 I	20c. Location - Baltimo	•	
Balt	permit. Pa Departmen important: any injury once.	21. Signature of Funeral Service Lic	ensee bolach 7	22. N	ame and Addre	^{iss of Fecility} Kac dalk Ave	zorows nue Ba	ski Fur altimon	neral	Home, PA
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ó	tificate be axecuted to physician and as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last								
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o.	tha d achec achec	Part II. Other significant conditions		suiting in the unde	nying cause giv	en in Paπ I.	236. Did t	1-0		he cause of death?
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Division of Vital Records, P.O.	Physician: The law requiras that tha death certificate be asscuted this certificate has been signed by the attending physician and ral diractor, pege 2 should be datached for usa as the burial-transit. To Be Completed by Physician/Medical Examir						24a. Was o	en eutopsy med?	availe	e autopsy findings able prior to pletion of cause eeth?
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of	shysic this contains al dire	1 ☐ Yes 2 ②PNo 27, Menner of Death	Hospital: 1 Inpatient 2		3 DOA Oth	4 Lithursing Hor		ence 6 Oth		
Sion	tal or Attending P rs efter deeth. al Director: After t led in by tha funare Certification:	2 Net lime of Death 1	he	<u> </u>		Yes 2□No				
Divi	To the Hospital or Attending Physician: The is within 24 hours efter deeth. To the Funeral Director: After this certificate ha completely filled in by tha funaral diractor, pege Medical Certification: To Be Com	4 Homicide determine	building, etc. (Specil	(y)			City or Tow			
	he Hospit in 24 hour he Funera pietely fill edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best of my kno aminer: On the basis of examina end manner stated.	owledge, death oc ation end/or invest	curred at the tir tigation, in my c	ne, date end place, e pinion, death occurre	nd due to the o	euse(s) and ma date and place,	nner as stat and due to th	ed. he cause(s)
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	1)	30. Neme and address of person who	o completed cause of deeth (Iter	n 23a) (Type, Prir	nt)	1111	0-1-1		2 1 1 11	u
	1/	31. Dete filed (Month, Dey, Year)	32. Registrer's Signa	oture -	ue 11 m	14/W/	40 / M	n, MY	10101	1
	State Registrar	MAR 2 9 200		Brook	1					

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2004 March 25, 7:00A Joseph Martin Pentz Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner College Manor Lutherville Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1ДM 2□F May 14,1935 68 Maryland Director 219-32-1848 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be putified at 1 ☐ Yes 2 ☐ No Lutherville Maryland Baltimore Direct 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 300 West Seminary Avenue 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 □ No 156-161 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or iter any injury or other traumatic event, the Medical Examinat 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify White If Yes, Give Year or Dates: Ď 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Developer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Pentz Martin Dorothy Mae Chambers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Friend 35 Parliament Court Baltimore, Maryland 21212 Hal C Whitaker 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2XXCremation 3 Removal from State 3/26/04 Greenmount Cemetery Baltimore, Maryland License gnature of Funeral Servi 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition muocardial immediate **Physician** resulting in death) /Medical Examiner vona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physiclan/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea use 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Dav jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 3 robably 4 Unknown 1 ☐ Yes 2 ☐ No been heave failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has page 2 certificate 2 No 1 Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Sother (Specify) CLSSisted Livin 2 4 No 1 Yes 2 ER/Outpatient 3□ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 5 Pending 1 Tes 2 No investigation 2 ☐ Accident 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifie D54664 March 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shanum Yuman (6565 N. Chanle 6565 N. Chanes Street, State 703 Balhmore, MD 21204 Snanuon 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 9 2004

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manuard Department of Health and Mental Hygiene State of Department of Depart William Mangham, Jr. 04 - 1937AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 2:50 PM **Physician** March 18, 2004 Mangham Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Temple Hills Prince George's 3006 Brinkley Road If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 € M 2 □ F 58 Yrs. GA 060-36-5106 Director Usual Residence of Decedent 10d. Inside City Limits Maryland 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23s or 28s-f show any injury or other traumatic event, the Medical Exercities must be notified at once. 1 ☐ Yes 2☐No Prince George's Temple Hills Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20748 3006 Brinkley Road T2 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify. Black þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) School Teacher 6yrs+ 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Lillian Clayton Willie Managham Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lillian Mangham Sr.-Mother 900 Grandconcourse, Bronx, NY 10454 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 3/24/04 Linder, Rosehill * 4 ☐ Donation 5 ☐ Other (Specify) March F/H West 21. Signature of Funeral Service Licensee 21215 nompour 4300 Wabash Ave, Baltimore Md Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Intracerebral Henorrhage Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Cocaine Use Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 1 Yes 2 No 2 No or Attending Physician: After this certification 26. Place of Death Check on one 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6XXDther (Specify) Hospital: At scene 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA ² 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of March 19, 2004 O.C.M.E. of death (Item 23a) (Type, Print) 30. Name and address of person 111 Penn Street, Baltimore, Maryland 21201 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2004 aparks Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09515 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Bel Air HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□F Months Days Hours Min 20-8125 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10b County 10d. Inside City Limits or 28a-f show Department of Health and Mental Hygiene. Important: if Nem 27 is markad other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Abingdon Director Har 10e. Street and Number 10f. Ziji Code 10g. Citizen of What Country? 21009 Woods Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ø Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+ spatcher 1 RANSIT rsite 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be oseph ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural H. ule Number, City or Town, State, Zip Code) 21009 Abingdon, MD larion 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Belfir Bel Air Nem. Gardens 3-27-04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility 3NEWPORT DR., FOREST HILL ymbeile EVANS FUNERAL CHAPEL-BELAIR, MD 21050 23a. Part1. Enter the disease, or or implication; that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each log. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ART STIVE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** MIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed ORDNARY that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, To Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? page ; certificate 2 No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 No Director: / 2 Accident 6 Could not be 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide Vithin 24 hours and To the Funeral Directory of the Funeral Directory To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

State 31. Date filed (Month, Day, Year)
Registrar

32. Registry's Signature

empleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year Halina Osinska 2004 March 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** nder 1 Year | If Under 24 Hrs. hths | Days | Hours | Min. 5. Social Security Number Baltimore Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Jan . 11, 1 Birthplace (State or Foreign Country) **Funeral** Days 1□M 2 F 069-50-1207 79 Poland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examinar nout be notified at 1 Yes 2 No Director Md. Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 106 Sandhill Road 21221 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Completed by 3 XWidowed 4 ☐ Divorced Year or Dates: "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) 8 t h College (1-4or 5+) Janitor 0 Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be t Department of Health and Mental I-Important: if item 27 is marked ottl any injury or other traumatic evan once. Be should be fi Maria Wardaszko unknown ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Krystyra Gladysz 106 Sandhill Road Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Bayview Crematory 3/29/04 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Lines See 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Cerebrova resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 □Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 🗙 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other. 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accidant Diractor 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide within 24 hours after To the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Physician Z0054303 dada

State Registrar

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square Drive, Baltimore, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Zayd Eldadah

MAR 2 9 2004

31. Date filed (Month, Day, Year)

9000 Franklin

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death Decedent's Name (First, Middle, Last) 2. Dete of Death Physician FIM 1)5 | ROVSKI /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BRIGHTWOOD NURSING HOME LUTHERVILLE BALTIMORE If Under 24 Hrs. 8. Date of Birth Month, Pay, Year, AUG. 12, 1919 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) UKRAINE **Funeral** 1 M 2□ F Months Days Hours 84 214-43-7414 Director Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours eftar deeth with the Manyland Department of Health and Mental Hygiene. Imprortant: If then 27 is marked other than "naturel", or items 23a or 28e-f eitow any Injury or other traumatic event, Im Mendical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Funeral Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6814 CHIPPEWA DRIVE 21209 UKRAINE 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 DN No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SALES INSURANCE 17 Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSTROVSKIY YAAKOV RACHEL (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN FERDMAN / DAUGHTER 6814 CHIPPEWA DRIVE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEMETERY 3/26/04 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** PROGRESSIVE DEMENTIA Immediate Cause (Final disease or condition resulting in death) /Medical ronth Examiner Due to (or as a consequence of): COROWARY ARTERY Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law raquiras that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, CARDIO MYOPATHY Due to (or as a consequence of) Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1_ Naturel within 24 hours eftar deeth. To the Funeral Director: A completaly filled in by the fu investigation 1 Tyes 2 □ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edicai 29a. Certifier ધ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 2 9 2004

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

GUPTA

29b. Signature and title of certifier

SHARUNMAZA

GENESI

DO05315

BRIGHTWOOD

29d. Date signed (Month, Day, Year) 3/25/2004

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BRIGHTWOOD

21093

DHMH 16 Rev 6/95

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	Examin	200	4a. Facility Name (If not institution	-	.00 1	4b. City.	Town, or Location of Death	1	4c. County of Death	
			Opper Un	esapoake	INIC	. CTr. If Linds	Year If Under 24 Hrs.	8. Date of Birth	9 Birtho	ace (State or Foreign
	Funeral		5. Social Security Number	6. Sex. 7.	Age (In yrs. las	O Yrs. Months		(Month, Day, Ye	ar) . Coun	ainia_
	Director	-	Usual Residence of Decedent	0 /	0	7		10-04-0	J4. V17	7/1//
	and	-	10a. State 10b. Count	у	10c. City,	Town or Location			1	Od. Inside City Limits
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	288 7	Je C	10e. Street and Number	11010			Code		Citizen of What Cour	try?
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	ms 2	Funeral Director	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	13. Was Dece	dent of Hispanic Origin? (S crly Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Americ Black, White,	
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3	be filed within 72 hours after death with the Maryland at Hygiene. A control of other than "natural", or items 23e or 28e-f show event, the Medical Examinal must be notified at	d by	3 Widowed 4 Divorce	d Year or Date	s:			100	Vind of Pusinger/In	// PC ·
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Š	should be nd Menta marked imatic ev	၉	19a. Informant's Name/Relation	nship (Type, Print)		19b. Mailing Addres	s (Street and Number or Ru	ıral Route Number, Ci	ity or Town, State, Zip	Code) 21084.
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อ์	Hee Hee		20a. Method of Disposition			ce of Disposition (Nametery, crematory or	me of other place)	Date 200	c. Location - City or To	wn, State
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g	Department Department Importment		Kemberly	W. saviole	اعا	EVANS	FUNERALCH	APEL-BEL	AIR. MD	21050.
			23a. Part1. Enter the disease shock, or heart failure.	or complications that callst only and cause on ea	sed the death.	Do not enter the mo	de of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	o. o,	MUM	randint	ratacti	cz		Onset and Death
	/Medical		resulting in death)	a. Due to (or	as a conseque	ence of):	1 1			. 05.1
	Examiner		Sequentially list conditions,	b	Myc	cardier	interest a	in .	-	T LOOK
	D #	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or	às a conseque	ence of):				
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9 ×	death certifica e attending ph id for use as th	by Physician/Med	IF FEMALE:	23c. If yes, outco					23d. Date of deliv-	ery
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Records,	quires n sign		tol	vacco ah	we			1 XYes	2 No 3 Prol	oably 4 Unknown
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	The lav	mo		11000				performe	d? death?	2 No
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0	Jing Ph After th funeral		27. Manner of Death 1 SNatural 5 □ Pen	28a. Date of (Month	Injury Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	injury occurred	
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Division of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	3 Suicide 6 Cou	mined 200. Flace	f Injury - At hor g, etc. (Specify	me, farm, street, facto)	ory, office	City or Town, S	et and Number or Rur State)	ai Houte Number,
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	thin 2 tha	Med	29b. Signature and title of cert		,	2	9c. License number	29d	I. Date signed (Month,	Day, Year)
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	140		30. Name and address of pers	on who completed cause	of death (Item	23a) (Type, Print)	11011	, ,	1	
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		ate	31. Date filed (Month Day Ye	9 q 2004 32. Rg	strar's Signat	ure L	<i>e</i> ,			
	Regist	rar	[11/71]	N U LUUT	CARLES SE	Jan Million				

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Jene Douglass Pack

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6:40 p MARCH 19, Physician MARGARET HOFFMAN PARTIN 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner MOUNT AIRY FREDERICK KLINE HOSPICE HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year MY 11, 1941 Birthplace (State or Foreign Country)
 OHIO 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Months Days 62 Yrs. 203-32-8608 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County in then "natural", or Items 23s or 28e-f show the Medical Exercitive must be notified at MARTINSBURG 1 Yes 2 No WV BERKELEY Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25401 USA 1503 W. STEPHEN STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry NATIONAL al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CANCER INSTITUTE MANAGER epartment of Health and Mental Hy, portent: If item 27 le marked othe y injury or other transcents. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be BARBARA REEBEL LEONARD FREDERICK HOFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1503 W. STEPHEN STREET, MARTINSBURG, WV 25401 JAMES DAVID PARTIN/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MARCH ☐ Burial 2 【XCremation 3 ☐ Removal from State SMITHSBURG, MD SMITHSBURG CREMATORY 1 4 ☐ Donation 5 ☐ Other (Specify) 24. 2004 permit.
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Importe
any inje 21. Signature of Funeral Service Licenses BROWN FUNERAL HOME, P.O. P.O. 227 327 W. 25402 Dean Macles m Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SWOWP **Physician** NO /Medical Due to (or as a c equence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician ar Division of Vital Records, P.O. Box 68760. Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown 23e. Did tobacco use cooribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 V o 3 Probably 4 Unknown 1 🔲 Yes should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s certificate 1 ☐ Yes 2 1 No or Attending Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 Inpatient 2 2 ☐ ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manuar of Death 28b. Time of 28d. Describe how injury occurred Certification; Injury 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. I Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 | Homicide within 24 hours after To the Funerel Dire To the Hospitel 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 1 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 21 Vew who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Dong (000) MP 31. Date filed (Month) Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 17 Rev 1/2001

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		Ŀ	1 - For Amend Item 10 Registrar	State of per FH,0	of Maryl 5829,03/	and / Depa 29/04dbb _e	artment of F	lealth and Death	Mental Hyg	iene 20	04	09520
			1. Decedent's Name (First, Middle	, Last)					2. Date of Deat Month		Year	3. Time of Death
	Physici /Medic		Charles		М.		P	erch	March			12:00a ^M
	Examin		4a. Facility Name (If not institution	give street and n	umber)		,,	r Location of Dea	th	4c. County o	f Death	
			Millennium Nu				Baltim If Under 1 Year					
	Funeral Director		5. Social Security Number 219-86-4141	6. Sex 1X M 2 ☐ F	7. Age (In)	Yrs. last birthday) Yrs.	Months Days	Hours Min		Year)	Coun	lace (State or Foreign try) Maica
	and and		Usuaf Residence of Decedent 10a. State 10b. County		10c.	City, Town or Lo	ocation				11	Od. Inside City Limits
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	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			Darcin	10f. Zip Code		10	0g. Citizen of Wh	nat Coun	try?
	h with		4012 West Roc	ers Ave	2		2	1215		U.S	. A .	
	e Has	Funeral	11. Maritaf Status		cedent Ever i	n U.S. 13.	Was Decedent of H	ispanic Origin? (Specify Yes or No- to Rican, etc.)	14. Race	- Americ	
9	hours after turel', or Ite		1 Never Married 2 Marri	ed 1 Tes	2 No		1 □ Yes 2√2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:		
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21215-0036	d within 72 ho giene. ar than "netur	Completed	15. Decedent (Specify only highes	t grade completed		(Give	kind of work done DO NOT use retired	during most of wo	orking	16b. Kind of Bus Amtrak Ra		•
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	₹ ₹	BeC	17. Father's Name (First, Middle,						me (First, Middle, M			
<u>a</u>		ဥ	Harold Perch					Emily	Gayle			
Maryland	2 sho and Is mu aumu		19a. Informant's Name/Relationsh					and Number or R	ural Route Number,			Code)
	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		Sophia Perch-	-Harvey	-Daugl	nter 67	02 Pars	ons Av				21215
ŏ	iges 1 it of ⊢ iffte or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		n State	cemetery, crer	natory or other plac			20c. Location - C		
Baltimore,	it. Pa rtman rtant: njury		' 4 □Donation 5 □ Other (S) 21. Signature of Funeral Service		D1		dge Cem		4/3/04 F	ikesvi	lle	, Md
Ba	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Fuller at Service	breh		Ma	rch F/E	West	Baltim	nore Mo	21	215
			23a. Part V. Enter the disease, or shock, or heart failure. List	only one cause on	each line.		-		4			Approximate Interval Between Onset and Death
	Physician	Sof a	Immediate Cause (Finaf disease or condition resulting in death)	_ a	05	teomyo	ldus OF	Inuvac	ic Spin	l		Oriset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a con	sequence of):	111.	1.60	•			
		F G	Sequentially list conditions, if any, leading to immediate	b. ————————————————————————————————————	o (or as a con:	sequence of):	Trriet	(((005				
	uted	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
o Î	axac an an rial-tr	Exa	resulting in death) Last	Due to	o (or as a con	sequence of):						-
8760	cate ba axacuted physician and the burial-transit	dicai		d								
9	artifica ing ph a as t	O I	IF FEMALE:								1	
Box	The law requires that the death cardifi lie has been signad by the attending l age 2 should be detached for usa as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pre birth 2 ☐ F	etal death 3	Ectopic pregnancy			23d. Date Monti		ry Day Year
o -	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9□Unk	gnant at time o nown	of death 5	Other (specify)					
۵.	that t ad by detac	h h	Part fl. Dther significant condition	ns contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the	e cause of death?
Records,	uires r sign ld be	d by							1 □ Ye	s 2/2/No 3	☐ Proba	ably 4 □Unknown
Ö	w require been si should b	iete							24a. Was an	24b. We	ere auton	sy findings available
Æ	sicien: The law certificate has b irector, page 2 s	Completed							autopsy	led de	ath?	osy findings available apletion of cause of
Vita		e e	25. Was case referred to medical					26 Place of De	1 ☐ Yes 2 ath (Check only one		Yes	2 No
	Physicien: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospitaf:	Inpatient 2	2 ☐ ER/Outpatien	it 3 DOA Oth		dome 5 ☐ Resider	-	(Specify)
0	ng Ph Iter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Pending		of Injury onth, Day Year	28b. Time of	28c. Injun Wor		28d. Describe how			
Sio	Attending F ir death, actor: After by tha funera	cati	2 Accident investig	ation				Yes 2 □No				
Division of	or Att	Certification;	3 Suicide 6 Could r 4 Homicide determi	ned 288. Plac	ce of Injury - A ding, etc. (Sp	kt home, farm, str ecify)	eet, factory, office		28f. Location (Str. City or Town,	eet and Number , State)	or Rurai	Route Number,
	pspitel hours a meral y filled		29a. Certifier 12 Certifyin	g Physicien: To th	ne best of my	knowledge, death	occurred at the tin	ne, date and place	e, and due to the car	use(s) and manr	ner as sta	ated.
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by tha to	Medical	one)	and ma	nner stated.	nination and/or in			urred at the time, da			
	To cor	-	29b. Signature and title of certifier	em			29c. Licenso		29	Marcil	wonin, L	200LL
					isa of dant '	ftom 22a) (Time-	Print)	5571		nunca	00	1
	3		Rame and address of person Saba	pally	201-1	09 150	ack Rel	ien Neck	Road	Balhm	ve N	2004 ayland 21221
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 2004	Sens.	Registrar's Si	Grature L	Day Val					

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:35 a M March 19 2004 Rieger /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Catonsville Baltimore St. Martin's Home-LSOP If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🗙 F 79 Director 1924 West Virginia 216-16-1525 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show other traumatic event, the Medical Examiner noust be notified at 1 ☐ Yes 2 No Directo Catonsville Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a 21228 United States death v Funerai 601 Maiden Choice Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 9 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 ie marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Garber Lambert Ada Lambert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) William Rieger / Son 7726 Eastdale Road, Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 3/23/2004 Baltimore, Maryland 14 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hubbard Funeral Home, Inc. poce 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Cardin Vascular Dise ase Physician /Medical Due to (or as a consequence of): **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physician P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetel death Year for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by should be 3 Probably 4 Unknown 1 Tes 2 🛍 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy periormed? (es 2 No certificate 1 Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: ٩ 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident after death 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funerel I completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ro the 29c. License number 29b. Signature and the of certifier 2164 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 2, 229 ekens SKARAV 3455 AMBANDAT 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 9 2004 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 25 RUSSELL, JR. **Physician** 3:15 P FREDERICK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Howard 16 Ruth Avenue Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral X**□M 2□F Yrs. MASS 71 July 8, Director 012-24-6993 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County or then "natural", or Items 23a or 28a-f show the Medical Examinational be notified at 1 ☐ Yes 2 No Howard Directo Maryland Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20727 United States 16 Ruth Avenue Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
Int: If item 27 is marked other then "natural", or Ite TXYes 2 ☐ No fYes, Give 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Printer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Aitken Earl F. Russell, Sr. or other treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15 Ruth Avenue Laurel, Maryland 20727 Gloria Russell - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☆Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Balt. Wash. Crematory 3/28/04 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., W. Pap 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transil the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregnancy Month Year for 4☐Pregnant at time of death should be detached 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No director, page 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 20 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury completely filled in by the funeral 27. Manner of Death After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of persol CAUREL, MARYLANDS 13435 BALTIMERE AVENUE DARRYL HILL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

MAR 2 9 2004

State of Maryland / Department of Health and Mental Hygiene 2001 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Remmers **Physician** arch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number Examiner Prince Georges Lanham Doctors Community Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 0ct 28, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 86 577-26-4141 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State Completed by Funeral Director Anne Arundel Annapolis 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1080 River Bay road 21401 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours atter a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other traumatic event, If a Medical Englishmens once. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3X Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charley B. White Virgie M. Morphew ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Remmers, Sr. /Son 1080 River Bay Road Annapolis, MD March 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State

Priysician /Medical **Examiner**

burial-tran nding physician as the use

The law requires that the death certiticate be executed

P.O. Box 68760,

Division of Vital Records,

Hospital or Attending

atter death. Director: At

within 24 hours a To the Funeral L

Examiner Physician/Medical by 2 Certification: 29a. Certifier

Approximate Interval Between Obset and Death Immediate Cause (Final disease or condition resulting in death) Preumonia Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniscae of Flury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

3□ DOA

Loudon Park Cemetery

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Congestive Heart Failure, Coronary Artery

Depression Dementiq

Mucular Degeneration

Disorder 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural 5 Pending investigation

20a. Method of Disposition

4 Donation

21. Signati

1

Burial 2 □ Cremation 3 □ Removal from State

5- Other (Specify)

eral Service Licensee

2 Accident 3 🗌 Suicide 4 Thomicide

(Check only one)

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

2004

Second Avenue, S.W. Glen Burnie, MD

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature Covering

29c. License number D31001 29d. Date signed (Month, Day, Year)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

09523

3. Time of Death

Birthplace (State or Foreign Country)
 D

U.S.A.

Baltimore, MD

Singleton Funeral Home, P.A.

1 Yes 2 ₹No

2 🖪 No

28d. Describe how injury occurred

24a. Was an autopsy performed

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

White

AR

10d. Inside City Limits

1 ☐ Yes 2 No

2:30 AM

eted cause of death (Item 23a) (Type, Print) 7500 Green war Cnyr. Dr. #430 Greenbell, MD lu okeari TZ, MD

State Registrar

31. Date filed (Month, Day, Year) MAR 2 9 2004 32. Registrar's Signature

MD

		-	1 - For State Registrar	State of M	aryland		artment of H		and Mental H	lygien Reg. N	200	4 09524
1	74	100	Decedent's Name (First, Middle, La.	st)					2. Date of Month		ay Yeer	3. Time of Death
	Physici		Francis James R	uss, Jr.					03	_	4 2004	6:31 P M
	/Medic Examin		4a. Facility Name (If not institution, give)		4b. City, Town, or	Location	of Death	4	c. County of Dee	oth
		4	Washington Adve	ntist Hos	nital		Tacoma	Park			Montgom	nerv
-	Funeral		5. Social Security Number 6. S	ex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Min. (Month,	Birth Day, Yea	9. Bir	thplace (State or Foreign ountry)
n	Director		217-28-1745	X]M 2□F	72	Yrs.	Months Days	riours	June	26,	1931 Pen	nsylvania
	P		Usual Residence of Decedent		140-00	T						10d. Inside City Limits
	how	L.	10a. State 10b. County		TOC. City	, Town or Lo	cation					1 Tyes 2 No
	Ba-f-	cto	MD Anne Ar	undel		Glen	Burnie					
	th th	Director	10e. Street and Number				10f. Zip Code			10g. 0	Citizen of What C	ountry?
	23a	lal	7822 Woodside Ter	race #20	03			061			USA	
	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	5. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Or n, Mexicai	igin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Ame Black, Whi	
98	or It		1 Never Married 2 XMarried	1 □XYes 2 □ If Yes, Give	1949		1 ☐ Yes 2€ No	Specify:			Specify: T.	Thite
21215-0036	72 hours after death with the Maryland natural', or Itema 23a or 28a-f ehow disal Examinar must be notified at	Completed by	3 Widowed 4 Divorced	Year or Dates:	1747					104		
5	72 h	ete	15. Decedent's En (Specify only highest gra	ducation ade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	furing mos	st of working	160.	Kind of Business	vindustry
12	within ene. then	dm	Elementary/Secondary (0-12)	College (1-4or	5+)	mo.	_					
	filed v Hygie other t		17. Father's Name (First, Middle, Last,	1			Owner		er's Name (First, Mid	Idle Maid	<u>Servi</u>	.ce
ind	be fi	Be	·						,		on Gamano,	
3	2 should be filed within and Mental Hygiene. is marked other then sumatic event, the Mental the Mental transfer is	은	Francis James R			105 14-75			ry Mayrich er or Rural Route Nu		var Taura State	Zin Code)
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heath and Mental Hygiene. ortent: If item 27 is marked other then "natural; or items 23a or 28a-f show injury or other traumatic event, the Madical Examinat must be notified at a.		19a. Informant's Name/Relationship (er or Hural Houle Nu race #203			
	1 and Health em 27 ther tr		Linda Russ / wif	e	20h BI		sition (Name of	101	Date	-,	Location - City or	
Baltimore,	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 Durial 2 Cremation 3 D	Removal from State	CE	emetery, crei	natory or other place	θ)	Daio	200.	Location - Oily of	TOWN, State
Ē	permit. Pages Department of Importent: If i any injury or once.		*4 □ Donation 5 □ Other (Specif				ke Cremat			St	evensvil	1e, MD
at	permit. Departi Import any inj		21. Signature of Funeral Service Licer		4		2. Name and Addres	s of Facili	ity Singlet	on F	uneral H	ome, P.A.
	897 29		Mare a lam		10135				e, Sw Gle		rnie, MD	21061
			23a. Part Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each	d the death tine.	. Do not ent	er the mode of dying	g, such as	s cardiac or respirator	y arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CORD	NAP	VA	RTERY !	Dice	ALP			Onset and Death
	/Medical		resulting in dealh)	Due lo (or a	s a consequ	ience of):	1/6/1		11)			July
	Examiner		Comments the time and distance	b								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequ	ianda of).						
	outed od ransij	Examiner	that initiated events	c.								
ó	es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit		resulting in death) Last	Due to (or a	s a consequ	ience of):						
760,	ysicie	cai		d								
68	certifical Iding physe as the	ledi										
Вох	andin use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth			Ectopic pregnancy				23d. Date of de	*
_	death of atten	icia	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnant :			Other (specify)			_	Month	Day Year
P.O.	oy the	hys	9 🗆 Unknown	9□ Unknown								
	requires that the een signed by the		Part II. Other significant conditions	-		-			t. 23e. C	id tobacc	o use contribute t	o the cause of death?
Records,	ening n sig	Completed by	Left ventri	CULAR	Dy	sful	vetion	/	1	☐ Yes	2 No 3 P	robably 4 🗷 Triknown
00		lete	RENAL FAI	lune						Vas an	24b. Were a	utopsy findings available completion of cause of
Re	The la	E	150019	101-0					_ p	utopsy erformed?	death?	
a	n: Ti ficate or, pa		25. Was case referred to medical	T				OC Diag	1 Ye		¶ 1 □ Ye:	s 2□No
Division of Vital	ding Physician: The law n. After this certificate has t funeral director, page 2 s	Be	examiner?	Hospital:			nt 3 DOA Othe		e of Death <i>(Check or</i> ursing Home 5 🗆 F		c COther (See	nalki)
of	Phy this rald	- To	27. Manner of Death			28b. Time o					jury occurred	9CITY)
2	ath. r: After	ion	1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year)	Injury	Worl	k? Yes 2.⊑			,	
isi	deatl ctor:	ica	3 Suicide 6 Could not b	OB Blace of It	niury - At ho	me farm st	reet, factory, office			n (Street	and Number or F	lural Route Number,
/≥	or A after Direction by	Certification;	4 Homicide determined	building,	etc. (Specify	")	, 120101y, 000			Town, Sta		
_	To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Pl	hveicies: To the bes	t of my know	wledge deat	h convered at the tim	no date a	nd place, and due to	the cause	(c) and manner a	e stated
	Hos 24 hc Fun Hely	Medical			of examinat				ath occurred at the tir			
	the the	Me	29b. Signature and title of certifier	//	Tutou.		29c. License	e number		29d. [Date signed (Mon	th, Day, Year)
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	1		// Jun	ae -	m			- / /		1 "	17 97	, ~~~ /
	/	1	30. Name and address . Herson who	completed cause of	death (Item	23a) (Type,	Print)	- 0.	20 2-	e Kari	110 40	20850
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		state Amend Item I. 1. Decedent's Name (First, Middle, I	per Dr.,G830,04/1	Rosenstr		Death	2. Date of Death	_{J. No.} 200	O Time of Dooth
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/Medi Exami		4a. Facility Name (If not institution, g NORTHWEST 14	ive street and number) OSPITAL CE	NTER	4b. City, Town, or RAN	Location of Deat	bw N	4c. County of Dea	MORE
Funeral Director			Sex XXM 2□ F 7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. Bi 915 New	rthplace (State or Foreign country) York
ryland how		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
r 28a-f a	Funeral Director	Maryland Anne A	Arundel G	ambrill	S 10f. Zip Code		109	g. Citizen of What C	1 ☐ Yes 2 XX No country?
th with	a D	905 Winter Have	n Drive		21054			nited Sta	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, Ita Medical Evarther in all to redified at any injury or other traumatic event, Ita Medical Evarther in all to redified at once.	Ď	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes XXNo If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes XXNo	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: W	
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and M		19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ing Address (Street	and Number or Ru	ural Route Number, (City or Town, State,	Zip Code)
anu ealth m 27 I		Karen Farbenblu	n/Daughter		the state of the s		e Gambril		
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Physician /Medical Examiner		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line.	omusi					Interval Between Onset and Death
be executed sicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons						
cate be executed physicien and the burial-transit	cal	resulting in oddiny bust	Due to (or as a cons	equence or):			·		
The law requires that the death certificate the bas been signed by the attending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pred 1 □ Live birth 2 □ F 4 □ Pregnant at time o 9 □ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	alivery Day Year
res mar igned b be deta	by Pt	Part II. Other significant condition:		resulting in the u	underlying cause giv	en in Part I.			to the cause of death?
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to the Hospital or Attends within 24 hours after death. To the Funeral Director: A completely filled in by the tr	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury - A building, etc. (Spe	t home, farm, st	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
se Hospita 24 hours ne Funera detely fille	ledical (Physician: To the best of my laminer: On the basis of exam and manner stated.						
To the within To the comp	Me	29b. Signature and the of certifier	1 PHYSIC	LAN		12723	m	Date signed (Mon PRCI+ 2	6 2004
	11	30. Name and address o erson wi	o completed cause of death (I	tem 23a) (Type	Print) Ala A	F 11 W 2 0	T 1205	01581	CENTER

State of Maryland / Department of Health and Mental Hygiene 0014 09526 State Registrar AMEND ITEM #8 PER FH G829 3/31/04 JBertificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27 March 2004 8:47 p. **REID 111 JOHN** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Roland Park Place 8. Date of Birth 0/1–08–1915 Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Days Hours 1 X M 2 □ F 88 Yrs 119-03-5538 April 18,1915 New York Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State item 27 is marked other then "natural", or items 23s or 28s-f show other traumstic event, the Medical Exeminar must be notified at XXYes 2 No Director Maryland n/a Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number U.S.A. 21211 830 W. 40th Street 12. Was Decedent Ever in U.S. Amed Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates: ₩₩ 11 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item any injury or other traumstic event, ILa Medical Expense 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager 4 Manufacture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Reid Jr. Amelia Olmsted John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Joan Reid (Daughter) 4300 Roland Ave. #104 Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/30/04 Greenmount Crematory Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-WiedefeldF.H.
6500 York Rd. 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or s a consequence of): infarction **Physician** /Medical weed **Examiner** Due to (o/all a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physicien ar s the burial-t Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed need 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No 25. Was case referred to medical 28. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No thours after death. 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 - Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD WE Drund I 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 N Chowles St #411 WEGLEIN DONBO 31. Date filed (Month, Day, Year)

MAR 2 9 2004 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / Department of Heal Certificate of Dea			Reg. No.	U4	09527
	9		1. Decedent's Name (First, Middle, Last)	2	Date of Dee	3. Time of Death		
10	Physicia /Medic	al -	GENEVIEVE C. ROY	City, Town, or Loca	MARCH			8:30p
1	Examin	er	44 Facility Name (II Not Institution, give street and name of	BALTIMOF		N/A	Death	
	F		5 Social Sequity Number 6, Sex 7, Age (In yrs. last birthday) If Under 1 Year If U	Under 24 Hrs. 8	Date of Birt (Month, Da		9. Birthpla	ce (State or Foreign
	Funeral Director		215-22-7856 1□ M 2以 F 85 Yrs. Months Days Ho	lours Min.	3-10-		MARYL	
	D .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				100	d. Inside City Limits
	Aaryla f sho	ŏ	MD. N/A BALTIMORE					1X☐ Yes 2 ☐ No
	r 28a-	rect	10e. Street and Number 10f. Zip Code			10g. Citizen of Wh	nat Country	y?
	15 with	a D	437 BLOOM ST. 21217			USA		
	r dea	une	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Speci Mexican, Puerto Ri	ify Yes or No can, etc.)	- 14. Hace Black	 Americar White, et 	
20	rs afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ □ No If Yes, Give 1 □ Yes 2 ▼ □ No Spin Sin □ Yes or Dates:	pecify:		Specify:	BLAC	K
21215-0020	filed within 72 hours after death with the Maryland Hygiene. Wher than "natural", or items 23s or 28s-f show ent, the Medical Examiner must be notified at	Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during	n na most of working	,	16b. Kind of Bus	iness/Indu	stry
2	ithin 19.	m pje	Elementary/Secondary (0-12) College (1-4or 5+)			COLLED	T1 (T11700	
5	iled w Hygiei ther th	8	-120- ADMINISTRATOR 17. Father's Name (First, Middle, Last) 18.1	. Mother's Name (First, Middle,	GOVERI Maiden Sumame		
au	d be f ental l ked of	To Be	CLARENCE E. CARTER SR.	NANNIE	BLACK	STON		
Maryland	shou and M s mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N					(ode)
Σ 	end 2 ealth m 27 i		DONNA M. QUEEN (GRANDDAUGHTER) 437 BLOOM ST. B	BALTIMORE	E, MAR	YLAND 212 20c. Location - C		m State
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Hygiene I have been that the notified at any fujury or other traumatic event, the Modical Examiner must be notified at any fujury or other traumatic event, the Modical Examiner must be notified at any fujury or other traumatic event, the Modical Examiner must be notified at any fujury or other traumatic event, the Modical Examiner must be not the fujury of the fujury or other traumatic event, the Modical Examiner must be not fujury or other traumatic event, the Modical Examiner must be not fujury event for the fujury or other traumatic event, the Modical Examiner must be not fujury event fujury ev		20a. Method of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) 20b. Place of Disposition (Name of cemetary, crematory or other place)) b c	ļ			
Ħ	artmea ortant Injury		4 Donation 5 Other (Specify) ARBUTUS MEMORIAL PAR 21. Signature of Fugeral Service LicenseeGUINEVERE REDD 22. Name and Address of	100 -		4 BALTIMO RAL SERVI		MARYLAND
Ba	Den imp		Leinevere Lodd 1721-27 N. M					AND 21217
	SERVICE OF THE PERSON		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sur shock, or heart failure. List only one cause on each line.	uch as cardiac or	respiratory a	rrest,	, 1	Approximate interval Between
	Physician		Lamadan Cours (First	. L. L-				Onset and Death
	/Medical Examiner	П	Immediate Cause (Finel disease or condition resulting in death) Breast cause we the account of the country we have a consequence of:	1316nC				2 90001
		ğ	Due to (or as a consequence or).				;	
>	v requires thet the death certificete be executed been signed by the attending physician end should be deteched for use es the bunel-trensit	dical Examiner	Sequentially list conditions, if any leading to immediate					
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Вох	death certiff e attending ed for use es	Physician/M	d					
O.	the at	ysici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in	n Part I.				the cause of death?
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rds	requires thet the seen signed by th should be deteche	ed by				an autopsy ormed?	avai	re autopsy findings lable prior to
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Vita	Physician: The raths certificate rather director, page	Be	examiner? Hospital: Other:	6. Place of Death	1	one) dence 6 □Othe	- /Canaiha	
5	this at di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	4☐ Nursing Hom		how injury occurre	. , , ,	
ion	Attending For death. Cotor: After by the funer	atlo	1 Anatural 5 Pending M 1 Yes	s 2□No				
Division of Vital Records,	or Attended efter death Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28	8f. Location (City or To	'Street and Numbe wn, State)	r or Hural	Route Number,
	To the Hospital or Attending I within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	ai Ce	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, d	date and place, ar	nd due to the	ceuse(s) and mar	nner es sta	ited.
	the Ho lin 24 I the Fu	ledicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated. 20c. Signature and title of cartifier.	27 125	d at the time,	29d. Date signed		
	To the within 7 to the comple	Σ	29b. Signature and title of certifier 02 12 29c. License nut 02 13 14 15 16 16 17 17 18 18 18 18 18 18 18 18	17.5		12	125	104
	_		30. Name and address of person who completed cauge of death (Item 23e) (Type, Print)	DA	H	oz ile u	1 -	107
	10) 1	Thomas foretsky 1075 tall 1	Lo Lo	lueru	ile, M	d	4015
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 2. 9. 2004 Secure 4 Signature			,		

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 2004 09528 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:30 A^M 22 2004 Rebecca L. Smith March /Medical 4h City Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 323 S.Bentalou St. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-12-1920 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** S.C Months Days Hours 1□M 2X0F 83 Yrs. 245-20-6678 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or Itams 23a or 28a-f show edical Examiner must be notified at 1 Yes 2 No Director Md Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 323 S. U.S.A. Bentalou St. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Black Baltimore, Maryland 21215-0036 ᇫ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d other than "natu Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be of Health and Mental. Fitem 27 is marked or r other traumatic eve Mingo Jenkins Mamie Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma Melvin 323 S. Bentalou St. Baltimore MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. N Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Cem. 3-29-2004 Crownsville MD 4 ☐ Donation 5 ☐ Other (Specify) Estep Bros. Funeral Serv. P.A. 21. Signature of Funeral Service Licensee E.N.Walker Jr 1300 Eutaw Place Baltimore MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Lardice montes Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the all d be detached for 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 1 Yes 2 No 3 Probably 4 Nunknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No has page certificate 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation in by the f within 24 hours after death To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital completely filled 1 Scrifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 29,2004 D-40521 325 HOSPITAL DRIVE SMITT 208 30. Name and address of person who are pleted cause of death (Item 23a) (Type, Print) DR. OCHANGY GLEN BURNE MOZIO61 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 9 2004

		Registrar 1. Decedent's Name (First, Middle, Last)	State of Maryland 1 Pa	eruncale of Death	2. Date of Death	No. 2001	3. Time of Death			
iciar		William Sturdina	nt		Month 03	25 200	4 0012 M			
dica nine		la. Fecility Name (If not institution, give s		4b. City, Town, or Location of De	eath	4c. County of Dear				
		University of Mari		Baltimore		N/A				
ıl r		210 31 7001	7. Age (In yrs. last birthd.	Months Davs Hours M	in (Month, Day, Ye	1950 May	thplace (State or Foreign buntry) LYLAND			
	-	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits			
1	ž A	Maryland Baltimore	2	Baltimore			1 ☐ Yes 2 🛣 No			
	∪ ⊢	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	ountry?			
		9118 Simms Avenu		21234		u.s.A.				
	by runeral	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit Specify: W				
1	9	15. Decedent's Edu	cation 16a, De	ecedent's Usual Occupation	168	b. Kind of Business	/Industry			
1	Completed	(Specify only highest grade	completed) (G	ive kind of work done during most of e. DO NOT use retired)						
	E	Elementary/Secondary (0°12)	2 Uni	formed Division	S	secret Se	rvice			
1	Re C	17. Father's Name (First, Middle, Last)	Villiam Wylie Stur	divant 18. Mother's	Name (First, Middle, Mai					
	0	-Wiley Sturd	ivant -			Jane Owens				
		19a. Informant's Name/Relationship (Ty		ailing Address (Street and Number or			_			
1	-	Mrs. Jean Sturdive		18 Simms Avenue,	The second secon					
		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation 3 ☐ F	emoval from State cemetery,	crematory or other place)		20c. Location - City or Town, State Baltimore, Maryland				
		*4 □Donation 5 □ Other (Specify)		Crematory 3/2 22. Name and Address of Facility S						
		21. Signature et Euneral Service Licens	LATE.	9705 Berair Rd.,			-			
	4	23e. Part I. Enter the disease, or compl	cations that caused the death. Do not				Approximate			
١		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of): Aortic occlu				Interval Between Onset and Death			
۱	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):		Faiture					
	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
	/slclan/M	/sician/M	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year	
.	2	Part II. Other significant conditions con	ntributing to death but not resulting in th	ne underlying cause given in Part I.			o the cause of death? robably 4 Unknow			
1	Completed				24a. Was an autopsy performe	d2 prior to death?	utopsy findings availabl completion of cause of s 2 No			
4	Be	25. Was case referred to medical examiner?		26. Place of	Death (Check only one)	-				
	2	1 Yes 2 No	fospital: 1 Inpatient 2 ER/Outpa		g Home 5 Residence		ecify)			
		27. Manner of Death Natural 5 Pending P	28a. Date of Injury (Month, Day Year) 28b. Tim	28d. Describe how	injury occurred					
	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,				
	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, oner: On the basis of examination and/oner and manner stated.	death occurred at the time, date and plor investigation, in my opinion, death o	ace, and due to the caus occurred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)			
1	Me	29b. Signature and title of certifier	,	29c. License number		. Date signed (Mon				
1		John Marl V	unil MD	P 1773	2	3/25/04 Greene S				
					77 5	Greene S	+.			
		30. Name and address of person who co		sity . & Marylan		e, MD 2				

State of Maryland / Department of Health and Mental Hygiene 2004 09530 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 2004 0408 M MAR 24 Joseph Elwo<u>od Smith</u> /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Bel Air Harford Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1☑M 2□F 90 March 3, 1914 Maryland Director 220-05-0929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 录No Fallston Md. Harford Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21047 United States 1318 Murgatroyd Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 □ Widowed 4 1 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) steel worker stee1 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be should be Jessie Wendall Saul Hugh Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1318 Murgatroyd Road, Fallston, Md. 21047 Joseph E. Smith, Jr./son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/30/2004 ^ 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gdns. Bel Air, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. Approximate Interval Between Onset and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician [ASPIRATION PNEUMONIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Saluentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown SEPSIS SYNDROME, PERFORATED DUODENAL ULCER, GI Bleed (PEDTIC WLEER) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ¥ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: Al investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital completely filled 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D45344 Milleugain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURESH DHANJANI, MD, 622 S. UNIONAVE, HAVRE DE GRACE, MD 2/0/B
31. Date filed (Month, Day, Year) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 9 2004

DHMH 17 Rev 1/2001

21215-0036

-Baltimore,

o.

Division of Vital

ORIGINAL

				Claic of Ma	,	Certificate of			Reg. No. 2 (004	09531	
			1. Decedent's Name (First, Middle, La	ast)				2. Date of De			3. Time of Death	
	Physici /Medi		GRACE	c. SILLO	WAY			March		004	4:35 AM	
>	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, or	Location of Death	4c. County	y of Death	1	
			Alice Byrd Tawes	Nursing Ho	ome		Crisfie			erset		
	Funeral Director		008-20-5094	Sex 7. Age 1 ☐ M 2 ☑ F	(In yrs. last bir 72	thday) If Undar 1 Year Months Days	r If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da January 2	y, Year)	9. Birthplac Country Verm	ce (State or Foreign v) IONT	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				100	I. Inside City Limits	
	fanyle aho ed at	5	, ,	rset	•	risfield				100	1⊠ Yes 2 □ No	
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country	n	
	ath with the Marylan 23a or 28a-f ahow ust be notified at		203 N. Somerset A	venue			21817			U.S.A.		
	death	Funerai	11. Marital Status	12. Was Decedent E	ver in U,S.	13. Was Decedent of If Yes, specify Cul		pecify Yes or No		ce - American		
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28a-1 ahow any injury or other treumatic event, I've Medicel Examera must be nutfiled at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:)	1 ☐ Yes 2 ☑ No		o Rican, etc.)	Specif	ck, White, etc y: Whit		
5-0	72 hc netui	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of wor	rking	16b. Kind of B	usiness/Indu	stry	
7	vithin ne. han "	μ	Elementary/Secondary (0-12)	College (1-4or 5+			ed)		7			
7	iled v Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Lasi	*)	B	ookkeeper	18 Mother's Nan	ne (First, Middle,	ACCOU			
an	should be fand Mental Fand Mental Fandswedt	Be c	Homer Clough	,				Rowell	water ourna	,,,,		
2	shoul nark	ဥ	19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Address (Stree			er. Citv or Town	. State. Zip C	ode)	
ž	nd 2 allth au		Charles Silloway	(Son)	20.	3 N. Somers	et Avenue	- Cris	field,	MD 21	817	
ře,	s 1 a of Hez item othe		20a. Method of Disposition	_	20b. Place of	Disposition (Name of y, crematory or other pla	ace)	Date	20c. Location	City or Towr	n, State	
E	Page nentc int: If iry or		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			bury Cremat		3/25/04	Sali	sbury,	MD	
a	permit. Departm Importa any inju		21. Signature of Puneral Service Lice	1/7	17	22. Name and Addr						
Ω	88 58		Robert H. Bra	dshaw. Ir		Bradshaw 306 W. Ma				21817		
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	pplications that caused to	he death. Do r	ot enter the mode of dy	ing, such as cardiac	or respiratory ar	rest,	A	pproximate Iterval Between	
1	Physician				1	,				0	nset and Death	
T	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	A:	SCVD				1		
		-E	resulting in death)	D	ue to (or as a d	consequence of):						
	nsit	Examiner		b		1.9						
~	execunation and ial-tra	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ue to (or as a c	onsayuanta of).						
68760,	te be ysicia ne bur	Cai	Under initiated events Due to (or as a consequence of).									
89 x	eath certificate be executed attending physician and I for use es the burial-transit	Medicai	resulting in death) Last							İ		
Box	es that the death cer igned by the attendin be deteched for use		Physician/I		u							
Р. О	The law requires that the death ete hes been signed by the atter page 2 should be deteched for u	ysic	Part II. Other significant conditions	-	not resulting in	the underlying cause g	iven in Part I.	./			ne cause of death?	
ਰ.	that t			· VA				1980	Yes 2□No	3 Probat	oly 4⊡Unknown	
g	uires n sign lid be	d by						24a. Was	an autopsy	24b. Were	autopsy findings	
Ŝ	w require been si should b	Completed						perfo	rmed?	availa comp of dea	able prior to eletion of cause eth?	
æ	he lar e hes age 2	E O						1 D Y	es 2 No		res 2□ No	
ta	ifficet tor, p	BeC	25. Was case referred to medical				26. Place of Dea	th (Check only o	• •		00 22.110	
<u> </u>	Physician: r this certific aral director,	To E	examiner? 1 ☐ Yes 2D No	Hospital:	2 ER/Out	tpatient 3□ DOA Ot		ome 5 Resid		er (Specify)		
0	ig Ph ter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of 28c. Injury Wo		28d. Describe h			-	
<u>ত</u>	Attending or death. sctor; After by the fune	catic	2 ☐ Accident investigatio	n]Yes 2□No					
Division of Vital Records,	or Attu efter de Directu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, fai <i>(Specify)</i>	rm, street, factory, office		28f. Location (S City or Tow		per or Rural R	loute Number,	
Ω	oital ours el		00-0-4/1-									
	To the Hospital or Attanding Physician: The law within 24 hours effect death. To the Funeral Director: After this certificate has: completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only one) 1 McCertifying Pt	nysiclan: To the best of niner: On the basis of e and manner state	xamination and	death occurred at the ti Vor investigation, in my	me, date and place opinion, death occu	, and due to the o rred at the time, o	cause(s) and ma date and place,	anner as state and due to th	e cause(s)	
	o the vithin o the omple	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signe	d (Month, Da	y, Year)	
	->-0			V 1	-6	DZ	18098	3/24/04				
	_		30. Name and address of person who	completed cause of dea	ath (Item 23a) (-1)_		
_	5		Vijay Karumbunat			• • • • • • • • • • • • • • • • • • • •	- Crisfi	eld, MD	21817			
	Sta Registr		31. Date filed (Month, Day, Year)	32 degistrar	's Signature	Souls!						
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Registrar DHMH 16 Rev 6/95

	•	1	_ State		epartment of Health a Certificate of Death		ene g. No. 2004	09532
	Physicia		Registrar 1. Decedent's Name (First, Middle, Last)		drew Slate	2. Date of Death Month March	Day Year	3. Time of Death 11:45a ^M
	/Medic Examin	-	4a. Facility Name (If not institution, give str 2725 Walbrook Av	eet and number)	4b. City, Town, or Location of Baltimore	1 1 7 1	4c. County of Death	١
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth (Month, Day, 09 16	Year) 42 9. Birth	nplace (State or Foreign untry) SC
	aryland show		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town				10d. Inside City Limits 1 ▼Yes 2 No
	th the M or 28e-f	Director	MD NA 10e. Street and Number	Daiti	10f. Zip Code	10	g. Citizen of What Co	untry?
9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Hauth and Mental Hygiene. item 27 is marked other than "naturel", or Iteme 23s or 28e-1 show other treumstic event, the Medical Evanting must be notified at	Funeral	1 ☐ Never Married 2 ☐ Married	2. Was Decedent Ever in U.S. Armed Forces? ▼TYPes 2 □ No If Yes, Give	21216 13. Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	U . S . A . 14. Race - Ame- Black, White Specify:	e, etc.
Maryland 21215-0036	hin 72 hours 8. 8n "naturel", Medical Erro	Completed by	3 ☐ Widowed M Divorced 15. Decedent's Educi (Specify only highest grade) Elementary/Secondary (0-12)	Year or Dates:	Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)		16b. Kind of Business/	Í
1d 21	e filed witi	Be Corr	9th grade 17. Father's Name (First, Middle, Last)	na	Housekeeping 18. Mother	r's Name (First, Middle, M	Hospit Maiden Sumame)	al
arylar	should be and Mental s marked o umatic ev	To	Niley Andrew Sla 19a. Informant's Name/Relationship (Typ	e, Print) 19b	. Mailing Address (Street and Number		City or Town, State, 2	
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree		Hester M. Slater 20a. Method of Disposition XIXBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	20b. Place of cemeter	25 Walbrook Av Disposition (Name of y, crematory or other place) son Forest Vet	Date 2	20c. Location - City or	Town, State
Baltir	permit. P Departme Importen any injur.		21. Sig ature of Funeral Service License		22. Name and Address of Facility March F/H Wes 4300 Wabash A	t.		21215
	Pnysician /Medical Examiner	Examiner	23a. Pan 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially, list non-titions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events)	Due to (or as a consequence	tive Hear	cardiac or respiratory arre	ilure	Approximate Interval Between Onset and Death
.O. Box 68760,	ie cleath certificate be executed the attending physician and hec for use as the burial-transit	Physiclan/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	Due to (or as a consequence ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown			23d. Date of del Month	ivery Day Year
Q	es that the igned by be detact	by	Part II. Other significant conditions con	tributing to death but not resulting in 151011	n the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
Il Recor	The law ate has b page 2 sl	Completed				24a. Was all autops perform	y prior to death?	utopsy findings available completion of cause of
Division of Vital Records,	ding Phyeicien: Th h. Affer this certificate funeral director, pag	lon: To Be	27. Manner of Death Natural 5 Pending		Other			cify)
Division	or Atteno ifter death Director: in by the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, for building, etc. (Specify)			reet and Number or Ri n, State)	ural Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C			e, death occurred at the time, date an nd/or investigation, in my opinion, dea			
	To the within To the comple	Me	29b. Signature and title of certifier	Press MA	29c. License number		9d. Date signed (Mont	1
	2		30. Name and advises of person who co	mpl. 1 ause of death (Item 23a)	(Typa, Print) Alameda A	faltimore	2 MD=	2128
	St Regist	ate rar	31. Date filed Month, Day, Year MAR 2 9 2004	32. Registrar's Signature	Ann de		•	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 10e,19b per FH, C830,04/07/04dhb

Tems 10e,19b per FH, C830,04/05/04dhb

Tems 10e,19b per FH, C830,04/05/04dhb

Certificate of Death

Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 24 2004 2245 William Stokes /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Med. Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 11 30 46 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Months Days Hours Min 57 Yrs Md. Director 212-44-6508 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "naturel", or Items 23e or 28e-f show other treumatic event, the Medical Examiner must be inclined at 1⊊Yes 2□No Directo Harford Abingdon 10e. Street and Number 3134 Laurel View Dr. 10f. Zip Code 10g. Citizen of What Country? 3134 Laurelview 21009 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Gov't 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 12 should be fi. h and Mental H 7 is marked ott Miriam Burns William Stokes Mirian 199 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 is m. eny injury or other-19a. Informant's Name/Relationship (Type, Print) Evelyn M. Stokes Wife 3134 Laurelview Dr., Abingdon, Md. 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet __3-30-04 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) CANGER OF COLON WITH METASTASIS TO LIVER **Physician** /Medical Due to (or as a consequence of) **Examiner** SEVERE GYPOXOGM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): Physician/MedIcal IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by REMAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 28 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 340 12 npatient 2 ER/Outpatient 3 DOA Certification: To 1 Tyes After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospitel or A within 24 hours after to To the Funerel Directory 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified here M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANUSHA. SIRITHARA, SUITE 206, 7505 OSLEND PRINE, TOWSON, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 9 2004

WILLIAM MSTOKE

ROBERT SANDERS
Unknown 04-084
04-01993
cm 1- §

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-01993 n		1- For Amend Item Registrar	state of the state	of Marylar h G830	4/2/02 Ce	artment of I tas rtificate of	Health an <i>Death</i>	d Mental H	ygiene Reg. No. 200	4 09534
Physic /Medi	ian Robert Sanders Marc					2. Date of D Month March		3. Time of Death 7:36 A M		
Exami		4a. Facility Name (If not institution 4100 Block Hyd		umber)	-	4b. City, Town, Baltim	ore		4c. County of D	/A_
Funeral Director		5. Social Security Number 218-86-8183 Usual Residence of Decedent	6. Sex 1 🕱 M 2 ☐ F	7. Age (In yrs. 27	last birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, L	irth 6-29-76 9. Day, Year) 76-	Birthplace (State or Foreign Country) Md.
e Maryland la-f show liffied at	ctor	Md a 10b. County	NA		y, Town or Lo altimor					10d. Inside City Limits 1X Yes 2 □ No
ath with the 23 or 24 out to 24	Funeral Director	10e. Street and Number 501 Doris Ave.	10.11.		0	10f. Zip Code 212		0./0	10g. Citizen of What	Country?
If yearly Z. I.Z. I.S. COOO should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Itams 23a or 28a-f show imatic event, the Medical Engineer must be notified at	by	11. Marital Status 1 ▼Never Married 2 Married 3 Widowed 4 Divorced	ried Armed F	2 (X No ive	-	was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🔀 No		? (Specify Yes or N Puerto Rican, etc.)	Black, W	hite, etc. Black
vithin 72 ho	Completed	(Specify only highe Elementary/Secondary (0-12)	1) (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of	working	16b. Kind of Busine	
d be filed wantal Hygier ted other to	Be	10th grade 17. Father's Name (First, Middle, Robert	Last)	Sand	Labor ders, S		18. Mother's	Name (First, Middl	Warehous de, Maiden Sumame) Starr	5e
D = m -3	2	19a. Informant's Name/Relations Mae Starr		Dan	19b. Mailin	ng Address (Stree	t and Number o	or Rural Route Num. altimore,	ber, City or Town, Stat	
Page nent o		20a. Method of Disposition 1		Julie	Place of Disponentery, cremetery, cremetery	esition (Name of matory or other pla		Date -26-04	20c. Location - City Lansdowne	
permit. Departm Importa any inje		21. Signature of Funeral Service	dup u) ane		Name and Addr March F.F	I. East	1101	imore, Md. E. North Av	
Physician /Medical		Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. HVL	each line.	EVA		ng, such as car		arrest.	Approximate Interval Between Onset and Death
The law requires that the death certificate be executed at has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	o (or as a consec	quence of):					
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VICAL DECO sician: The law re certificate has bee lirector, page 2 sho	Completed							24a. Wa auto per 1 🗷 Yes	formed? death	autopsy findings available to completion of cause of ? Yes 2 \(\subseteq \) No
ng Physician: free this certificineral director.	Certification: To Be	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (S 27. Manner of Death 1 Natural 5 Pending Natural 5 Pending Natural 5 Pending Pending							SHOT Rural Route Number,	
To the Hospital or Attendition 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Ce	29a. Certifier 1 Certifyin (Check only one)	Examiner: On the	STREET ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred at the t vestigation, in my	me, date and popinion, death o	lace, and due to the	DENCT, BALT e cause(s) and manner e, date and place, and c	as stated.
To the vithin To the comple	Med	29b. Signature and title of certifie				29c. Licen	se number		29d. Date signed (Me March 22,	
n Si	ate	31. Date filed (Month, Day, Year,	10, MD	use of death (Itel	111		ceet, Ba	altimore,	Maryland 2	
Regis	trar	MAR 2 9	2004 /		to de					

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		-	For State Registrar	State of Maryland		rtment of H			ene g. No. 2	004	095	536	
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) 13 ARBARA A,	VICKERS				2. Date of Death Month MARCIA	Day 27	2004	3. Time of 8:50	Death A M	
	Examin	er		OSPITAL CEI			LLSTOW	7	BA	anty of Death			
	Funeral Director		5. Social Security Number 3.18-76-7479 Usual Residence of Decedent	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 7,1944		place (State of http:// LYLANC	or Foreign	
	a-f show	ctor	10a. State 10b. County Baltim	OPL BO	Town or Loc	eation ORI				1	0d. Inside Ci	-	
	23a or 28	Funeral Directo	10e. Street and Number 5901 Cappoll S	4reet		10f. Zip Code	28	10	g. Citizen	of What Coul	ntry?		
036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show free Mexical Evertinal resal be rodified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 (XNo If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White, ecify:			
21215-0036	be filed within 72 hours after death with the Marylan Ital Hyglene. Id other than "natural", or Rems 23s or 28s-1 show event, Ita Medical Exactinat mast be notified at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give I	ent's Usual Occupa kind of work done do O NOT use retired,	luring most of wor		6b. Kind o	of Business/In	dustry		
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	s 1 and 2 should f Health and Mer tam 27 is marke other traumatic		Sandul J. V/C	Kees	416	Address (Street a	And Number or Ru	Date Number	PA	wn, State, Zip 1730 on - City or To	8	•	
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Ba	Depar Impor any ir		21. Signature of Emeral Solvice Lightse	Self	88	Name and Address	clord Rd	ians tu 2 Baltir	nera	MA	2/234 Approximat	/	
	Physician **Afedical Examiner	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence to consequence)	nowla						Interval Bet Onset and	ween Death	
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Division of Vital Records,	iician: The law rec certificate has bee rector, page 2 shou	Completed	CARCINOMA	of Col	, No			24a. Was ar autops perform 1 Yes 2	/	death?	psy findings mpletion of c	available cause of	
<u> </u>	Physiciar this certif al directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Xnpatient 2 🗆 E	ER/Outpatien	3 DOA Othe		ath (Check only one dome 5 - Reside		Other (Specif	y)		
o uoi	Attending Physician: r death. ector: After this certifics by the funeral director, t	ation:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28c. Injury at Work? 1 Yes 2 No								
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ı	To the within To the comple	Me	29b. Signature and the of certify r	PHYSICIA	N	29c. License	2723	m	ARCIT	9	Day, Year) 201	04.	
	5		30. Name and address of person who co		23a) (Type, I ARIS)	+ 54	RTHWE OL OL	T COURT	PIT	AD AD	m) g	N1 33	
¥.	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 9 200	32. Pogistrar's Signat	ture	ack i							

State of Maryland / Department of Health and Mental Hygien 200 L 09537 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Harry Robert Wille, Jr. March 20, 4:10 a 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Pasadena
If Under 1 Year If Under 24 Hrs.
Hours Min. Anne Arundel 8247 Bayside Drive 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 11XM 2□ F 217-20-1867 Director 77 Jan 4. 1927 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r then "naturel", or Items 23s or 28s-f show the Medical Examinar must be nutified at 1 ☐ Yes 2 No Maryland Anne Arundel Director Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8247 Bayside Drive 21122 United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours atter ent of Health and Mental Hygiene, when if item 27 is marked other then "naturel, or ite any or other treumatic event, the Medical Exemina 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Narried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) Pharmacy Pharmacist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry R. Wille, Sr. Emma Lena Heintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne J. Wille / Wife 8247 Bayside Drive, Pasadena, Maryland 21122 of Disposition (Name of Date 200. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Loudon Park Cemetery 3/25/2004 | Baltimore, Maryland Donation 5 Other (Specify) 21 Signature of Funeral Service Licens 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Cancer **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy ło in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ funeral director, page 2 should be Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 🔼 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has To the Hospital or Attending Physician: Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Alter this 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Natural
Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) arole Miller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Canaly Miller
31. Date filed (Month, Day, Yeer) ave Caton 32. Registrar's Signature State MAR 2 9 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene ? 09538 For State
Registra AMEND ITEM #30 PER DVR G829 3/29/04 Gentificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ATKING. Month **Physician** ANE Marcy 2 00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE
ear If Under 24 Hrs.
ays Hours Min. BON SECURE HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth
JUNE 30, 1946 Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 ☐ M 2 🖾 F 57 Yrs. MD Director 212-46-3382 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MD BALTIMORE NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 975 NORTH HILL ROAD Items 23s Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
sint: If item 27 is marked other than "Fatural", or Items 23a ury or other traumatic event, in Medical Exprires intuits. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black. AFRICAN 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced AMERICAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 9th 0 NONE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROSE WATKINS JAMES E. BARKLEY ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is ony injury or other tra JACKSON (DAUGHTER) 5009 **AVENUE** BALTIMORE, MARYLAND TASHAUN FRANKFORD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/29/04 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION CEMETERY LANSDOWNE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WYLIE FUNERAL HOME 638 N. GILMOR STREET BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) aridonis metallole **Physician** /Medical Due to (or as a consequence of): **Examiner** 1212 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner noteNS(CN The law requires that the death certificate be executed and burial-tran Due to (or a) a consequence of): attending physician for use as the buria P.O. Box 68760. IMMUNODEFICIENCY Physician/Medicai tF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 Tes 2 🗆 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a autopsy perioritied? has page 2 certificate 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA this 28c, Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М death. 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Direct 1/2 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signatury and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 37203 G-MI 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SECOUR HOSPITAL BALTIMORE, MD. DR TERANCE L. LAMB 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 9 2004

			1 - For State Registrar	State of Marylar	id / Depa	artment of F	lealth and	Mental Hygi	ene 200	4 09539
	Physici /Medio Examin	cal		WHI TNE street and number) GIONAL HO	SPETAL	LA	r Location of Deat		Day Year 25 05 4c. County of De PRINCE	GEORGES
	Funeral Director		5. Social Security Number 6. Sec. 218–26–1976 1 Usual Residence of Decedent 10a. State 10b. County]M 201F	last birthday) 4 Yrs. Ty, Town or Lo	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, 03 17	Year) 9. 8 1730 Ma	rthplace (State or Foreign Jounty) Tyland
	with the Mar 3a or 28a-f st	Funeral Director	Maryland Prince Ge 10e. Sireet and Number 9001 Cherry Lane	eorges	Laur	10f. Zip Code 2070	08		g. Cilizen of Whal C	•
920	72 hours after death with the Maryland natural; or Itams 23a or 28a-f show Utal Ezama ne muni be motified a	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	l⊡Yes 2⊠No	Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify:	erican Indian, ite, etc. White
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Maryland	2 should and Mer 1s marks sumatic	To Be	Ernest Peregoy 19a Informant's Name/Relationship (Ty Emory Whitney - Hus				Katheri		City or Town, State,	
e,	of Heal of Heal fitsm 2 r other		20a. Method of Disposition 1 ★ Burial 2 Cremation 3 F '4 Donation 5 Other (Specify)	20b. For State	Place of Disposemetery, crem	sition (Name of natory or other place lge Mem.	Park 3/	Date 2 28/04	oc. Location · City o	r Town, Slate Maryland
Ball	permit. Pag Department Important: I any injury o 2003-		21. Signalure of Funeral Service Licens 23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat	h. Do not ente	er the mode of dyin	ng, such as cardia	or respiratory arres	e At MMP. idge, Mar	, Inc. yland 21075 Approximate Interval Between
	Physician //Medical Examiner per period partial per period per period per period per	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulling in death) Last	Due to (or as a conseq ARTE Due to (or as a conseq HYPE Due to (or as a conseq	uence of): $REO = 0$ uence of): $RTEO$	ARTE SCLER NSION	osis.	SEASE		Onset and Death SEVERAL
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Οİ	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th		(Check only 2 Medical Examil	building, etc. (Specify sician: To the best of my known oner: On the basis of examina	v) wledge, death	occurred at the tin	ne, date and place	City or Town,	State)	s stated
ł	To the 1 within 2- To the 6 complete	Medical	29b. Signature and title of certifier Addition	and manner stated.	D.	29c. Licenso		290	d. Date signed (Mon.	th, Day, Year)
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Physici		1. Decedent's Name (First, Middle, Las				nt of He		2. Date of D	eath			3. Time o	Deat
			Charles W	. Warı	nick,	, Jr.		Month March	Day	2. 20	ear	6:07	78
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		Johns Hopkins Bay	view Medical (Center	В	altimo				N	/A		
uneral		5. Social Security Number 6. S	ex 7. Age (In yrs	s. last birthday,	If Und Month		If Under 24 Hrs Hours Min		irth ay, Year)	9	Birthpla Counti	ace (State	or For
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el', or items 23a or 28a-f show Exempler count be notified at	Director	Maryland Balt 10e. Street and Number	imore		10f. Z	Zip Code	Dund	alk_	10g. Citi	zen of Wha	at Counti	ry?	
3a or	<u>-</u>	7448 Lawrence	Road				21222		Un	ited	Stat	tes	
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or He		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🔀 No If Yes, Give				Specify:	to rican, etc.)			White, e	tc.	
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ther other	- 6	20a. Method of Disposition		Place of Dispo	osition (N	ame of	1	Date	20c. Lo	cation - Cit	y or Tow	m, State	
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important: if Item 27 is any Injury or other trai since.		In In	- L. 1/1//	Ī	Duda-	Ruck I	uneral	Home of	Dun	dalk,	Inc	2	
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Registrar

	1	For State Registrar	State of I	Marylar		artmen <i>rtificat</i>			and M	lental Hyg	giene Reg. No. 2 (004	0954
Physician /Medical Examiner	4	I. Decedent's Name (First, Middle, L ANNIE LAURA la. Fecility Name (If not institution, gi RIVERVIEW CARE (WRIGHT ve street and numb			ESS	SEX	Location o		2. Date of Dea Month MARCH	Day 24, 4c. Count BALT	Year 2004 y of Death IMORE	3. Time of Deat 7:30
Funeral Director		5. Social Security Number 6. 213-30-6414 Usual Residence of Decedent	Sex 1□M 2⊠F	76	last birthday) Yrs.	If Under Months		If Under a	Min.	8. Date of Birt (Month, Day 12-12	v. Year) 2-1927	9. Birthp	elece (State or Fore htry) VA
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23e or surither	5	10e. Street and Number 152 CHESTNUT STI	REET			10f. Zip	2122	2			10g. Citizen of US.		ntry?
al', or Items	2	11. Marital Status 1 □ Never Married 2 □ Married 3 ሺ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? M∆ No		Was Deced If Yes, spec			gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ce - Americ ck, White,	etc.
	ווואופופ	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12) 12	Education ra de completed) College (1-4	or 5+)	(Give	dent's Usua kind of wo DO NOT us MAKE	rk doné d se retired,	lurina most	of worki	ng	16b. Kind of B		dustry
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ysician and by C. Department of Hear Area and by C. Important: If Item 2 by D. D. D. D. D. D. D. D. D. D. D. D. D.		JANES WRIGHT/SC 20a. Method of Disposition 1 \[\] Burial 2 \[\] Cremation 3 4 \[\] Donation 5 \[\] Other (Special Constitution of the Consti	Removal from State Property of the control of the	sed the death line.	Place of Dispondentery, creft ROWNSVI	TALE OF THE MODEL	me of other place. CEMET and Address I LA le of dying.	ERY S of Facility URENS g, such as	4-2- JAME S STE	REET BAT	20c. Location CROWNS' DRTON & TIMORE rest,	- City or To VILLE SONS	wn, State
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is certificate director, pag To Be Col	3	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:		758/0		Othe	r _/		(Check only of			
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within 24 hours after To the Funaral Dir completely filled in Medical Cert		(Check only 2 Medical Example) 29b. Signature and title of certifier	iminer: On the basi and manner	s of examina	ation and/or in	vestigation,	in my op	inion, deat	h occurre	ed at the time, o	late and place,	and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 03:53PM March 2004 MADELINE BAVATO ZIELINSKI /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Baltimore Good Samavitan H0901 6. Sex 7. Age (In yrs. last birthday) Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1□M 2√2F Director 220-05-7967 Jan 28, 1920 | Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "neturel", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 3615 Elmora Avenue USA Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: ģ White 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other then Elementary/Secondary (0-12) College (1-4or 5+) Federal Courts Deputy Clerk 12 yrs permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other traumatic event 90%. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Trevisonno 2 Ernest Bavato Carmella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen F. Deyesu (Nephew) 1402 Winsted Drive, Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Sunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaffice of Fundral Service Discharge St. Stanislaus Cem 3 3/30/2004 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ,5e10419 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit eval Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy į in the past 12 months? Month Year Day 4☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate has 2 No 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 29c. License number Res 000 Colin 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5404 Legin Raven Blvd. Baltimore, MD 21239 teaturov 6 The oracle Signatus State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 ls Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** Louis Zaranski, Sr. MARCH 24, 9:27 pmM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept. 4, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-03-7420 84 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow nutified at 1 XYes 2 □ No Director Md. n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? The 23a or 801 South Belnord Avenue 21224 USA Funerai 12. Was Decedent Ever in U.S. Amed Forces? 1 ⊠Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural', 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Zaranski unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis G. Zaranski, Jr./son 3 Woodholme Village Court Balto., Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ō Important: If it 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Holy Rosary Cem. 3/31/04 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses once Fundo J 1201 Dundalk Avenue Balto., Md. 23a. Part1. Enter the disease or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PSIS /Medical Due to (or as a consequence of): **Examiner** neumana Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician the burial Box 68760. Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ rull M 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 28 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check on one Hospital: 1 €Inpatient 2 ☐ ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo ဥ this 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Alter the Hospital or Attending 5 Pending 1 Natural Injury death. 1 ☐ Yes 2 ☐ No investigation I Director: / 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Smalls D0051347 30. Name and address of persop who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St. Baltimore MD 21204 Soriano MI CYNTHIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 2 9 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 200 4 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** Michael Anderson 2004 6:35AM MARCH /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Lanham Doctors Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days 12XM 2□ F 238-92-9690 45 Maryland 02/05/1959 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Item 27 is marked other than "natural", or Items 23a or 28e-f show other treumstic event, the Medical Examinar must be notified at 1 Yes 2 □ No Director Prince Georges Mitchellville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11205 Chantilly Lane USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 23 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within intent of Health and Mental Hygiene. ent: If Item 27 Is marked other than " College (1-4or 5+) 3yrs Elementary/Secondary (0-12) Government Computer Specialist 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oscar Anderson Miriam Brewton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11205 Chantilly Lane, Mitchellville, MD Health Item 27 Miriam E. Anderson/Mother 20721 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or pnce. Evening Star Mem.Cemi03/10/04 * 4 ☐ Donation 5 ☐ Other (Specify) Greenwood, S.C. 22. Name and Address of Facility J.B. Jenkins Funeral Home 21 Signature of Funer I Service Licenses Þ 7474 Landover Rd., Landover, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical ple Sclerons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) o been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 s Jas performed? 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred Certification: Alter or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospitet 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical c mpletely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) MSD 30666 completed cause of death (Item 23a) (Type, Print) 30. Na and address of pers MERCANTILE LANE SUITE DIT LANGO MS 20174 140 OHN W GENERU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 2004 Registrar

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		For State Registrar		Ce	ertificate of		Reg. I	per co (2 1	0 3 0 7
Physicia	n	1. Decedent's Name (First, Middle,				M	ate of Death onth	Day Yeer	3. Time of Death
/Medica		Grace Alexa						2004	12:05 p
Examine	er	4a. Fecility Name (If not institution,				or Location of Death		4c. County of Deatl	1
		Suburban Ho		Marina land hindada	Bethes // If Under 1 Year		to of Dieth	Montgomer	
Funeral Director			6. Sex 7. Age 1	95 (In yrs. last birthda) 95 Yrs.	Months Days	Hours Min. (M	te of Birth lonth, Day, Yea 20,	9. Birth Con	nplace (State or Forei
rector	ł	275-30-2213 Usual Residence of Decedent				NOV	. 20, .	1908 Ark	ansas
14		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit
tien 27 is italizated ottan train italizate, of reins 23s of 20st show other traumatic event, the Medical Examiner must be routlied at	to	MD Mont	gomery	Silver S	Spring				1. ØYes 2□N
	Director	10e. Street and Number 2201 Colsto	n Drive #40	3	10f. Zip Code 209]	0	10g. (Citizen of What Cor	untry?
E	Funerai	11. Marital Status	12. Was Decedent I				es or No-	14. Race - Amer	ican Indian
	E	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 🛣	lo		Hispanic Origin? (Specify Y an, Mexican, Puerto Rican,	etc.)	Black, White	, etc.
j	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: B1	.ack
	Completed	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	Dation	16b.	Kind of Business/I	ndustry
	e E	Elementary/Secondary (0-12)	College (1-4or 5	+) (Gr	DO NOT use retire	during most of working d)			
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	Be (17. Father's Name (First, Middle, L.	ast)			18. Mother's Name (First	, Middle, Maid	en Sumame)	
	0	Robert M. C	aver			Sophia Ca	rter		
		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Ma	ling Address (Street	and Number or Rural Rout	e Number, City	y or Town, State, Z	ip Code)
		A. Melvin Alexa	nder/Son			n La, #421 Be	thesda	, MD 2081	.4
5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Plamoval from State	20b. Place of Dis- cemetery, cr	position (Name of ematory or other pla	Ce) Date	20c.	Location - City or 7	Town, Stete
		*4 Donation 5 □ Other (Spe		Western	Res. Mem.	Gdn 3/11/04	Che	esterland	, OH
any injury or once.		21. Signature of Funeral Service Li	densee	0	22. Name and Addre	ess of Facility Strick			
ē 3		The W. X	tuffer	1	500 Aller	ntown Rd. Cam	p Sprir	ngs, MD 2	0748
		23a. Enter the disease, of control of the control o	omplications that caused nly one cause on each fir	the death. Do not e	nter the mode of dyir	ng, such as cardiac or resp	iratory arrest,		Approximate Interval Between
ian		Immediate Cause (Finaf disease or condition	ANOXI	c EN	CEPHAL	OPATHY		1	Onset and Death
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	ne	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of).					
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	dical	'	d						
2 3	Physician/Med	IF FEMALE:	23c. If yes, outcome	of process					·
יכן טפל מא נויס טעוימן-וומוואון	an	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy	у		23d. Date of deliver Month	very Day Year
De detached for use	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	time or death 5	Other (specify)				•
ď		Part II. Other significant condition	s contributing to death be	ut not resulting in the	underlying cause on	ven in Part I	3a. Did tohacci	n use contribute to	the cause of death?
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7 13	S					1[performed? ☐ Yes 2 🖸		202No
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ctor.	-	1 Yes 2 No	Hospital: 1 Inpatie			4 Nursing Home 5			ify)
d rector	0	27. Manner of Death		Year) 28b. Time Injury	Wor	rk?	escribe how in	jury occurred	
	0	1 Natural 5 ☐ Pending	t he			Yes 2 □No			
c F	0	2 Accident investiga		ury - At home, farm, s c. (Specify)	treet, factory, office	28f. Lo	cation (Street a ty or Town, Sta	and Number or Rur ite)	al Route Number,
C	0		building, etc						
	Certification: To	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	building, etc						
ם פנוסו	Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only 2 Madical E	Physician: To the best of xaminer: On the basis of	examination and/or	ath occurred at the til	me, date and place, and du opinion, death occurred at the	e to the cause ne time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
ć	Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	Physician: To the best of	examination and/or	nvestigation, in my o	opinion, death occurred at the	ne time, date a	nd place, and due	to the cause(s)
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led in by the funeral director.	Certification: To	2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	Physician: To the best caminer: On the basis of and manner sta	examination and/or ited.	29c. Licens	opinion, death occurred at the	29d. C	Date signed (Month)	to the cause(s)

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State of Maryland / Department of Health and Mental Hygiene 09548 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year RAYMOND FREDERICK ANTHRACITE MARCH 8:38 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 9423 JONGRONER COURT POTOMAC MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) JULY 21, 1 6. Sex Birthplace (State or Foreign Country)
 NEW YORK 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 59 1944 Director 153-34-1661 Usuel Residence of Deceden with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ir than "natural", or Items 23s or 28s-f ahow the Medical Exeminal must be notified at 1 Yes 2 No **POTOMAC** MONTGOMERY MD. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? JONGRONER COURT 9423 Funeral 20854 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 XYes 2 No If Yes, Give 1973 Year or Dates: 199 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced 1993 WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN HEALTH CARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fiit.
Department of Health and Mental Hy
Important: If item 27 Ia marked oth
any injury or other treumatic event Be RAYMOND FRANCIS ANTHRACITE ROSIE MARIE CIMLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONGRONER COURT, POTOMAC, MD. 20854 NANCY E. ANTHRACITE/WIFE 9423 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 3-11-2004 RIVERDALE, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

CHAMBERS FUNERAL HOME & CREMATORIUM, P.A Chame M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician PANCREAS** CANCER 4 WEEKS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Hospital: 1 🗀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Certification: To 2 FB/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) Haggerty Wester M. 1941 D32407 MARCH 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

9707 MEDICAL CENTER DR.#300, ROCKVILLE, MD.20850

HAGGERTY,

MD,

32. Registrar's Signature

JOSEPH M.

MAR

31. Date filed (Month, Day, Year) MAR 11

			1 - For State Registrar	State	of Marylan	d / Depa	artmen rtificat	t of H	ealth a Death	ind M	ental Hy	/giene Reg. No.	200	04	0954	9
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	Examin		4a. Facility Name (If not institution,	give street and no	umber)		4b. City,	Town, or	Location o	f Death			County of I			
			HEBREW HOME OF					CKVII		14 Ura	(5		IONTGO			
	Funeral Director		5. Social Security Number 224-05-1252	6. Sex 1 □ M 2 □ F	7. Age (In yrs. 85	last birthday) Yrs.	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D APRIL	av. Year)	.918 V	Country /IRG	ce (State or Foreigr V) LNIA	7
5-0036	I within 72 hours after death with the Maryland jiene. r than "naturel", or Items 23a or 28a-f show the Madical Examinar man be notified at	ed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MARYLAND 10e. Street and Number 8313 RAYMOND La 11. Marital Status 1 Never Married 2 Marria 3 Widowed 4 Divorced 15. Decedent	12. Was De Armed F 1 _ Yes If Yes, G Year or	pedent Ever in U corces?	16a. Dece	10f. Zip 2 Was Dece II Yes, spe 1 Yes	0854 dent of His cify Cubar 20X No	Specify:	, Puerto F	cify Yes or N Rican, etc.)	UNI o-	zen of Wha TED S 14. Race - / Black, V Specify:	TATI American	ES n Indian, c.	
Ç	thin 72 8. an "nat Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give life.	kind of wo DO NOT u	rk done d se retired,	lurina most	of workir	ng				,	
7	filed within Hygiene. wher then "	Son	12			HOI	MEMAK	ER					OWN F	IOME		
land	m - 0 5	0	17. Father's Name (First, Middle, I	SIEGEL						rs Name RAH	(First, Middle		Sumame) SENST	EIN		
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic and other.		19a. Informant's Name/Relationsh BERT ANKER, SO	nip (Type, Print)			-				OMAC,	_	Town, Sta 20854	te, Zip C	ode)	
Baltimore,	ges 1 and of Heal		20a. Method of Disposition 1 ☑ Burial ② ☐ Cremation			Place of Dispo cemetery, crea	osition (Nai matory or c	me of other place	1		ate		cation - City			
	tant:		`4 Donation 5 □ Other (S)	7 /	HE	BREW C				3/9/	2004	HAMP	TON,	VIRO	GINIA	_
pa	Depar Impor any ir		21. Signarure of Fundal Service 21. Signarure of Fundal Service 22. Signarure of Fundal Service 23. Part 1. Enter the disease, or	1./82	zi.	D.	ANZAN	SKY-(HIE	ERG 1	MEMORI , ROCK	VIIIF				
760,	Physician / Medical Examiner prize p	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	o (or as a consequence of or a consequence of or a consequence of or a consequence of or as a consequence of or a consequence or a consequence or a consequence or a c	ualice of).	4	av	r ter	-7	de	Sea				
P.O. Box 68	the death certific by the attending p ached for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregna birth 2 Peta gnant at time of c known	it death 3	⊒Ectopic p □ Other (s)					2	23d. Date of Month		ay Year	
_	w requires that been signed be should be deta	by	Part II. Other significant condition	ons contributing to	death but not res	ulting in the u	inderlying (ause give	en in Part I.				se contribu ⊒No 3[cause of death?	,
al Records,	The ate has bage	Completed									pen	s an opsy formed?	prior	r to comp	y findings available detion of cause of	•
₹	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital				Othe			(Check only			-	· · · · · · · · · · · · · · · · · · ·	-
Division of Vital	Phys this aldi	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Dat	☐ Inpatient 2 ☐ e of Injury onth, Day Year)	28b. Time of Injury		28c. Injury Work		2	ne 5 Res			Specify)		_
Divisi	or Atten after dea Director d in by the	Cerlification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Pla	ce of Injury - At h Iding, etc. (Special	ome, farm, st	reet, factor	y, offica	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2		(Street and own, State,		or Rural I	Route Number,	
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	To the within To the	Me	29b. Signature and title of certifie	r			29	c. License	number			29d. Dat	e signed (M	Aonth, Di	ay, Year)	
)	1		30. Name and address of person 31. Date filed (Month, Day, Year)	Mi	and			11: 4	1490	フ		Ma	ch	7,	2004	
	V		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type,	Print)	000	USUE	40	1	Line	won n	2		
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State of Maryland / Department of Health and Mental Hygiene 2004 0955

1. Decembers, Name, Plant, March, Lard 1. Decembers, Name, Plant March, Advance 1. Decembers, Name, Plant March, 1. Decembers,					•	Certifica	te of Death		Reg. No. 200	4 09550
Montgomery Social Security Number Social Security Security Social Security Number Soci		DI		nst)		-	-	2. Date of Dec	eth	
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Since Social Security Number 18th No.			4a Fecility Name (If not institution, gir	re street and number)			4b. City, Town,			
Secial Second Number Case			Montgomery H	lospice- Ca	sey Hou	se			Montgom	ierv
This is the state of the stat		Funeral	5. Social Security Number 6.	Sex 7. Age	(In yrs. last bir	thday) If Und		rs. 8. Date of Birt		
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Sagratio Gonzalez	3	H H H)		COUIL I		ame (First Middle		ent
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23a. Part I, Enter the deases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest. Approximate individual and provided and prov						500 Un	iversity Blv	d. W., Si	lver Sprin	ng, MD 20901
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 3 3 4 4 1 1 Yes 2 No 3 3 4 4 1 1 Yes 2 No 3 4 4 1 1 Yes 2 No 3 4 4 1 1 Yes 2 No 3 4 4 1 1 Yes 2 No 3 4 4 1 1 Yes 2 No 3 4 4 1 1 Yes 2 No 3 4 4 1 1 Yes 3 1 Yes 2 No 3 4 4 1 1 Yes 3 1 Yes 2 No 3 4 4 1 1 Yes 3 1 Yes 3 1 Yes 3 1 Yes 3 1 Yes 4 1 Yes 5 Yes 6 . ·	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Cancer of	Oue to (or as a c of the I Oue to (or as a c	onsequence of onsequence of	:				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death?		nding Jsa g	resulting in death) Last	d	ue to (or as a co	onsequence or)				1
24b. Was an autopsy findings available prior to completion of cause of death? 25c. Was case referred to medical examiner? 1	,	the street the street	Part II. Other significant conditions of	ontributing to death but	not resulting in	the underlying	cause given in Part I.	23b. Did to	bacco use contribut	e to the cause of death?
State Stat		ined by e datac			_			1□ Y	es 2□No 3⊠F	robably 4 ☐ Unknown
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre M.D. 10400 Connecticut Avenue, Kensington, MD 20895 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	3	S Page S						TUY	S 2 X NO	1 ☐ Yes 2 ☐ No
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugene P. Libre M.D. 10400 Connecticut Avenue, Kensington, MD 20895 State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	9	in 24 hour the Funeral filling ledical (one)	nner: On the basis of e	xamination and	death occurred or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the ca curred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
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Eugene P. Libre M.D. 10400 Connecticut Avenue, Kensington, MD 20895 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	•	4	21	Lebr	e M	0	d09470		March 8,	2004
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		7	30. Name and address of person who o	completed cause of dea	ith (Item 23a) (T	ype, Print)	171		_	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	-		Eugene P. Libre M	.D. 10400	Connec	ticut A	venue, Kensi	ington. MT	20895	
Registrar MAR (19 2004) Service D Asocial			31. Date filed (Month, Day, Year)	32. Registrar	s Signature	1 1				

State of Maryland / Department of Health and Mental Hygiene 2001 09551 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 10,2004 12:52p M Mohammad Ali March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery 112 Bates Ave. Gaithersburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) | 0 Ct. 5, 1926 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1以M 2□F 77 220-02-9454 Lebanon Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or items 23s or 28s-f show other treumatic event, the Medical Examiner must be notified at 1X□Yes 2□No Maryland Montgomery Gaithersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Bates Ave 20877 Lebanon death by Funerai 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Exami 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Oil Industry Mechanical Engineer 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hassan Ali Afifeh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maha Nada/ Daughter 112 Bates Ave, Gaithersburg, Md. 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Geo. Wash. Cemet. 3 - 12 - 04Adelphi, Md. 22. Name and Address of Facility Universal II Mortuary Inc. 21. Signature du uneral Service License Kennedy St, N.W., Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ule der disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ray Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Oue to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 1 Yes 2 XNO funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitel within 24 hours To the Funeral 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) To the and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0 3 196) 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shady Grove Rd, Gaithersburg, Md Robert Gold, M.D 15225 31. Date filed (Month, Day, Year) MAR 12 32. Registrar's Signature State 2004

Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 09552 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** CANDACE LEIGH BROOME MARCH 04, /Medical 2004 11:58 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner National Institutes of Health Bethesda 8. Date of Birth (Month, Day, Year) Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 256-96-1059 35 Yrs Director Georgia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1⊠Yes 2□No Funeral Director Gwinette Suwanee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1454 Oglethorpe Dr. N.E. 30024 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ☐Yes 2 XNo 1 ☐ Never Married 2X Married 5 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No ģ If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 'neturel' Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife 4yrs. None I Hygie 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) .. Pages 1 and 2 should be fit thent of Health and Mental H tent: if item 27 is marked ott jury or other treumatic even D. Edward Young Patricia Ann Perkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1454 Oglethorpe Dr. Suwanee, Georgia 30024 19a. Informant's Name/Relationship (Type, Print) Jim Broome - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: if any injury or QDCE. Hillandale Mem. Gar. ' 4 ☐ Donation 5 ☐ Other (Specify) 3-9-04 Lithonia, GA. 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th St. N.W. Washington Washington, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) KESPIRATORY TAILURE **Physician** HOUR) /Medical Due to (or as a consequence of) Examiner BLEED GI WEEKJ Sequentially list conditions of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed burial-transit MCNTH) CELL attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Day Year 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 XNO 3 Probably 4 Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 2 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29b. Signature and title of entific 29c. License number 29d. Date signed (Month, Day, Year) MD 3313 MD 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEAM NITIN 10 CENTER DRIVE, BETHESDA, MARYLAND 20892 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 2004 Registrar

			1 - For State Registrar	State of Ma	ıryland		artment of				Reg. No.	04	09553
	Physici		1. Decedent's Name (First, Middle, La	st)						2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic		Muriel			Bry				Mar.	3,	2004	6:46 a ^M
	Examin	er	4a. Fecility Name (If not institution, giv		-		4b. City, Town		n of Death		4c. County		
			Washington Advent: 5. Social Security Number 6.5		a⊥ ı (İn yrs. las	t hirthdayl	Takom		er 24 Hrs.	8. Date of Bir		gomer	
	Funeral Director			M 2€ F	88	Yrs.	Months Da			Month, Da	19, Year) 5, 1916	Jama	ace (State or Foreign try)
			Usual Residence of Decedent							Journ 10	3, 1310	Odino	1100
	yland	. [10a. State 10b. County		10c. City,	Town or Lo	ocation					11	Od. Inside City Limits
	a Ma	cto	Maryland Prince	Georges	Hyat	tsvi	11e						1 X Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Cod				10g. Citizen of V	What Coun	try?
	ath w	ra	1909 Chapeman Road	·		1	2078						s America
	er de item	Funeral	11. Marital Status 1 ☑Never Married 2 ☐ Married	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 [XN		13.	Was Decedent of If Yes, specify C	of Hispanic (Cuban, Mexic	origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)		e - Americ ck, White, o	
36	irs aft	byF	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🙀 I	No Speci	ity:		Specify	· Bla	ck
215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f ehow fra Madical Examinar mast be multified at	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Oc	cupation		ina	16b. Kind of Bu	usiness/Ind	ustry
218	hin 7	pie	(Specify only highest gri	College (1-4or 5	+)	life.	kind of work do DO NOT use re	tired)	IOSE OF WORK	ung			
21	filed with Hygiene. other the	Completed	12			Hous	sekeepe				Owned		
nd	d oth	Be	17. Father's Name (First, Middle, Last)							, Maiden Suman	10)	
<u>\Z</u>	should be filed withir of Mental Hygiene. merked other than matic event, tra M	မ	George Bryan	Time Cried		405 14-15	- Add (Ct-			loney	Ch T	Chair Tin	Codol
Maryland	2 2 2 3		19a. Informant's Name/Relationship (May McLarty/Daught	**							er, City or Town, Le, MD 2		C000)
-	1 and 2 Health tem 27 i		20a. Method of Disposition	rer	20b. Plac	ce of Dispo	sition (Name of	f		Date	20c. Location -		wn, Stete
101	Peges nent of int: If it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci		1	-	natory or other.		2/11	./2004	Brentwo		
Baltimore			21. Signature of Fatheral Service Lice		1010							ou, n	aryland
B	permit. Departr Importa any inji		X/ron &	will.			345F B13	ncoln adensb	Funer ourg k	al Home	entwood 1	Mary1	and 20722
	515		23a. Part 1 Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death.	Do not ent	er the mode of	dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cardi	o pu	lnes	man	tan	lura			3	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a co seque	nce of):	. /	-	1				1
	LAdiminei	_	Sequentially list conditions,	b. Due to lot as	live	Ca	dide	15	- M	u		- 2	evenlyzar
	ed isit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to tor as	a conseque	nce or).						- 1,	hura time
	be executed ician and burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or as	a conseque	nce of):							June
760,	te be e ysiciar ie burii	calE		d									
68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit												
Вох	n cert endin use	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			∃Ectopic pregna	ancy.				e of delive	
	death or u	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify				Мо	nth	Day Year
P.0	at the by the	Phys	9 Unknown										
	The law requires that the tite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions	contributing to death bu	it not result	ing in the u	nderlying cause	given in Pa	nı.	239. Did t	/		e cause of death? ably 4 Dunknown
orc	requi	eted									-		
Records,	The law cate has be page 2 s	Completed								24a. Was autoj	psy	Were autor prior to con death?	esy findings available apletion of cause of
alF				-1						1 ☐ Yes	2 No		2□ No
Vital		Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		210		Other	-75	h (Check only o			
of	Phys r this sral di	. To	1 Yes 2 No 27. Mann of Death	1 V npatie 28a. Date of Injur (Month, Day		R/Outpatier 8b. Time o	11 3L DOA	njury at Work?	Nursing Ho		dence 6 Oth how injury occurr)
O	Attending r death.	itior	1 V atural 5 ☐ Pending 2 ☐ Accident investigation		Year)	Injury		Work? 1 ∐ Yes 2	□No				
Division	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide		iry - At hom	e, farm, sti	reet, factory, offi	ice	- 4	28f. Location (. City or Toi	Street and Numb	er or Rura	Route Number,
Ö	ospitel or hours afte uneral Dir	Cert	4 Hornicide	building, etc	(Эрвспу)					City or Tol	wn, State)		
	t hour uner	icai	(Check only 2 Medical Exe	hysician: To the best ominer: On the basis of	of my knowl examinatio	edge, deat	h occurred at th	e time, date	and place, leath occur	and due to the red at the time.	cause(s) and ma	nner as stand due to	ated. the cause(s)
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	Medical Certification:	one) 29b. Signature and title of certifier	and manner sta	ted.			ense numbe			29d. Date signed		
	vith CO CO		▶ MM	ann T.	M		D	1990	15		Mari	7 7	074
0	1		30. Name and address of person who	completed cause of de	eath (Item 2	(Type	Print) . A			^	- Iwan	1/	105510
1	0		MOBARAK K	ARIM, 76	10 C	ARR	OLLH	ENV:	Ei/H	KOMA	PARK	7 19	D20912
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 9 200		ar's Signatu	To the	1.						

			1 - For State Registrar	State of Manen	daryland frem	Depa IZe	artment of	GHE Of E	ealth a Death	364PE	ental Hy 4 tas	giene Reg. Na	20	04	09	551
A Tig.	Physici		1. Decedent's Name (First, Middle, La Otto John Beye	ist)			1				2. Date of De Month Februal	ath	Ď, 2	004	3. Time 8:05	
	/Medic Examin		4a. Facility Name (If not institution, gi				4b. City, Tov					40		of Death	eorges	
	Funeral Director		Social Security Number 6.		Age (In yrs. last	birthday) Yrs.	If Under 1 Y		If Under 2 Hours	Min.	8. Date of Bir (Month, Da Feb 12	th av. Year)		9. Birth	place (State intry) de Is1	or Foreign
Maryland	f ahow	tor	Usual Residence of Decedent	Georges	10c. City, To		cation ge Parl	k							10d. Inside (City Limits s 2 ☐ No
with the	a or 28a Lbe ozti	I Director	10e. Street and Number 8712 35th Avenu				10f. Zip Co						izen of \	What Cou	ntry?	
1215-0036 Within 72 hours after death with the Maryland	natural', or Items 23s or 28s-f ahow dical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 A Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 M Yes 25 If Yes, Give Year or Dates	s? 2N o 45-46	- 1		of His Cuban		in? (Spe Puerto	ecify Yes or No Rican, etc.)		14. Rac	e - Ameri k, White,	can Indian, etc.	
U-CLZ	pene. r than "natur ine Medical	Completed	15. Decedent's Elementary/Secondary (0-12)	ade completed) College (1-4o		(Give life.	dent's Usual O kind of work d DO NOT use re	one du etired)	iring most					usiness/lr		
	al Hygi I other vent, I	To Be Co	17. Father's Name (First, Middle, Las Otto Wilhelm			M	echanio		18. Mother	's Name	: (First, Middle Apitz	, Maiden		& D	ie	
, Mary and 2 shou	alth a		19a. Informant's Name/Relationship Barbara Beyer-		1		ng Address (St		nd Number	or Rura	l Route Numb	er, City o			o Code)	
Pages 1	Department of Health Important: If Item 27 I any injury or other tre		20a. Method of Disposition 1 Burial 2 Cremation 3 Company of the		ceme	tery, crer Lind		r place) ema	tory	2/2	7/2004	Brei	ntwo	od M		
Ball	Depart Import any inj once.		21. Signature of Funeral Service Lice / Myclin T. Wil	detMoi	322	34	01 B1a	den	sburg	g Rd	t Linco Brentw	ood				
Ex	nysician Medical kaminer	iner	23a. Par1. Enter the disease, or consolon, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Respi Due to (or a	ratory as a consequence ation P	Failu se of): neumo	ıre								Approxima Interval Be Onset and	etween
. BOX B8/BU, death certificate be executed	physicien and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequenc	ce of):										
	by the attending place as to tached for use as t	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		ne of pregnancy 2		Ectopic pregn Other (specify						23d. Dat Mor	e of deliventh	ery Day	Year
S, T	been signed b should be deta	by P	Part II. Other significant conditions	contributing to death	but not resulting	g in the ur	nderlying cause	e given	in Part I.			obacco u Yes 2	_		he cause of pably 4	
I Kec	ate has page 2	Completed									24a. Was autor perfo 1 Yes		l p	rior to co leath?	psy findings mpletion of	available cause of
OI VILA Physician:	certificate irector, pag	Be c	25. Was case referred to medical examiner?	Hospital:		_		Other			(Check only o	0.00				
	death. tor: After this the funeral di	ertification: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident		jury 28t	o. Time of Injury	28c.	Injury a Work?	4 Nurs	2	ne 5 Resid				y)	
5 8	Dir	O	3 ☐ Suicide 6 ☐ Could not to determined	building,	njury - At home, etc. <i>(Specify)</i>						8f. Location (S City or Tox	vn, State)			mber,
the Hospital	하는 하는 하는 하는 하는 하는 하는 하는 하는 하는 하는 하는 하는 하	ledical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the bes miner: On the basis and manner:	of examination	lge, death and/or inv	occurred at the restigation, in r	ne time my opir	, date and nion, death	place, a occurre	nd due to the	cause(s) date and	and mai place, a	nner as s and due to	tated. the cause(s)
Tot	within 2 To the I complet	Σ	29b. Signature and title of certifier	1297-	l) (T	29c. Lic		number						Day, Year)	
- (5) Sta	ite	30. Name and address or person who 1111 Spring St., 31. Date filed (Month, Day, Year)	Silver Sp			V	ehe	yis N	Negu	ssie					

			1 - For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artment tificate	of H	ealth a Death	and M		giene (2004	0955
10 m	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last Curtis Caross Bec 4a. Fecility Name (If not institution, give	ton	ur)		4b. City, 1	Town, or	Location o	of Death	2. Date of De Month 02	29	Year 04 unty of Death	3. Time of Death 7:27am
100	Funeral Director		Prince George's Ho 5. Social Security Number 6. Se 244-76-6852		Age (In yrs. la	ast birthday) Yrs.	Chev If Under Months	1 Year	If Under a	24 Hrs. Min.	8. Date of Birl (Month, Da 06/18	Prin	Cou	rge's place (State or Foreign intry) th Carolina
	D	tor	Usual Residence of Decedent 10a. State 10b. County MD Prince Ge	eorge's		Town or Lo	cation over H	ills	3		00/10	71940		10d. Inside City Limits 1図Yes 2 No
	ath with the 23s or 28s	Funeral Director	10e. Street and Number 7719 Emerson Road					2078				Unite	of What Cou	•
9036	ours after de iral', or Items Examiner o	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates	s?] No	'	Was Decede f Yes, speci l ☐ Yes 2		spanic Origin, Mexican, Specify:	gin? (Spe , Puerto i	crfy Yes or No Rican, etc.)	i	Race - Ameri Black, White, ecify: B1a	, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "natural", or Items 23s or 28s-f show event, the Madical Examiner and be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th	cation e <i>completed)</i> College (1-4o	r 5+)	(Give life. I	lent's Usual kind of work DO NOT use echan:	k done d e retired)	tion u <i>ring m</i> ost	of worki	ng		of Business/In	idustry
ıryland	od at a	To Be (17. Father's Name (First, Middle, Last) Charlie Becton 19a. Informant's Name/Relationship (Ty	roe. Print)		19b Mailic	n Address	(Street a	Nora	В.	(First, Middle, Taylor Route Numbe			o Codo)
ore, Ma	and 2 eaith a m 27 is		Gayle Becton/ Wife 20a. Method of Disposition 1 Surial 2 Cremation 3 DF		20b. Pla	7719 : ace of Dispo	Emerso	on Re	d. L	ando	ver Hil	ls, M		5
Baltimore,	permit. Pages 1 Department of H Important: If Ite any injury or otl		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens			22		Address	s of Facility	J.B	1/2004 . Jenki Landov	ns Fui	neral l	Home
17	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or compleshook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	Due to (or a	ed the death. line. L C C C C C C C C C C C C C C C C C C	ARD/ ence of):	AC		RHY			rest,		Approximate Interval Between Onset and Death
8/60,	certificate be executed adding physician and use as the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a conseque	ence of):								
O. Box 6	~ = -	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Fetal	déath 3□	Ectopic pre					23d.	Date of delive	ery Day Year
ecords, P	wrequires that the death been signed by the atte should be detached for	by	Part II. Other significant conditions cor	ntributing to death	but not resul	ting in the ur	derlying cau	use giver	n in Part I.				contribute to the	he cause of death? pably 4 Munknown
VITAL MEC	The lay ate has page 2	e Completed	25. Was case referred to medical								24a. Was a autop: perfor 1 Yes	sy med? 2 12 No	b. Were auto prior to con death? 1 Yes	psy findings available mpletion of cause of
o	shys this al di	ertification; To Bo	examiner?	1 ☐ Inpat 28a. Date of In (Month, D		R/Outpatient 28b. Time of Injury		Other c. Injury Work	4 □ Nurs	sing Hom 2	(Check only or ne 5 ☐ Reside 8d. Describe h	ence 6 🗆		()
DIVISION	by o	O	3 Suicide 6 Could not be determined	1	etc. (Specify)						City or Tow	n, State)		il Route Number,
	To the Hospital or within 24 hours after to the Funeral Dii completely filled in	Medical	29a. Certifier (Check only one) 1 V Certifying Physical Examinates (Check only one) 29b. Signature and title of certifier	ner: On the basis and manner s	or examination	ledge, death on and/or inv	estigation, ii	t the time n my opi License	nion, death	place, a	d at the time, d	ate and plac	manner as st ce, and due to ned (Month, i	the cause(s)
			30. Name and address of rison who		death (Item :	23a) (Type, F	Print)	000	0 56	43	O EVERLY,	-		* .
	Sta Registr		**MAR 0 9 2004	32. Regis	3001 trar's Signatu		AL &	YKIVE.		CHE	VEKLY,	1VI)	×07E	15

			1 - For State Registrar	State of	Marylar	nd / Depa		t of H	ealth a		fental Hy	gien	е) () (L	no	1556
	Physici /Medi		1. Decedent's Name (First, Middle, La Dorothy Ann Beach								2. Date of D Month March	2, D	2004	Year	3. Time 1:26	of Death P M
	Examir		4a. Fecility Name (If not institution, giv 12813 Duckettown		ber)			Town, or	Location o	of Deeth		1		y of Death e Geo	rge	
	Funeral Director		5. Social Security Number 6. S 579-56-4240	Sex 7	. Age (In yrs.	. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B	irth	45	Cour	lace (State try) Lngto	e or Foreign n DC
	Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G	eorge		ity, Town or Lo	cation					-			0d. Inside	City Limits
	with the	Il Direc	10e. Street and Number 12813 Duckettown	Road			10f. Zip	Code 708					itizen of	Whal Cour	itry?	
960	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel", or Itema 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Microred	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	as? A⊡ No	- 1	Was Deced If Yes, spec		spanic Origin, Mexican,	gin? (Spe , Puerto	ecify Yes or N Rican, etc.)	0-	Bla	ce - Americ ck, White,	elc.	
21215-0036	within 72 ho ene. than "natu he Modical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-	4or 5+)		dent's Usua kind of wor DO NOT us od Se	rk done d se retired,	uring most	of worki	ing			usiness/ind		
Maryland 2	should be filed withind Mental Hygiene. I marked other than umatic event, the M	To Be Co	17. Father's Name (First, Middle, Last, James Ryan								(First, Middle Unobta:	, Maider	n Sumar		18 	<u> </u>
	t and 2 sho Health and tem 27 is m			Type, Print)	100	1614	Cambi	ridge	Road	d E	dgewat	er M	D 21	037		
Baltimore,	permit. Pages 1 Department of He Importent: If ites eny injury or oth		20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	y)	210	Place of Dispo cemetery, crer rt Linc	oln (ther place Ceme t	ery	3/6	/2004	Bre	ntwo	od, M	D	
Bai	permit Depar Impor eny in		21. Signature of Funeral Service Licer			341	OT BT	aden	sburg	Rd.	Linco , Bren	twoo	uner d, M	al Ho ID 207	me 222	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Met	ine.	ic Brea				cardiac o	er respiratory a	irrest,			Approxim- Interval Bi Onset and	etween
760,	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classase or injury that initiated events resulting in death) Last	c	as a consec											
P.O. Box 6876	death certific e attending pi d for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∏Pregnai 9☐ Unknow	h 2 ☐ Feta nI at lime of c m	aldeath 3 death 5 death	Ectopic pre	ecify)						te of delive	ry Day	Year
Ś	w requires that the been signed by th should be detache	by	Part II. Other significant conditions o	ontributing to dea	th but not res	sulting in the ur	nderlying ca	lusə givə	n in Part I.		II			nbute to th 3 ☐ Proba		
al Record	The law ate has b page 2 sl	Completed									24a. Was auto perfo 1 Yes		(Were autoportor to condeath?		s available cause of
Vital	S =	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ Inc	atient 2	ER/Outpatien	3 DO	Othe			(Check only one 5 ₹ Resi		6 (TO#h	or (Coorie		
ion of	ding P. After fune	ation; T	27. Manner of Death 1 ⊠ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of (Month,		28b. Time of Injury		Bc. Injury Work	at	2	28d. Describe					
Division		Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury - Al h	ome, farm, stre	eet, factory,	office		2	28f. Location (City or To	Street an wn, State	nd Numb e)	er or Rural	Route Nul	nber,
	To the Hospital or within 24 hours after To the Funerel Direction completely filled in	edical	29a. Certifier (Check only one)	ysician: To the b niner: On the bas and manne	s of examina	owledge, death ation and/or inv	occurred a estigation,	it the time in my opi	e, date and nion, death	place, a	and due to the ed at the time,	cause(s) date and) and ma d place, a	nner as sta and due to	ited. the cause((s)
	To the H within 24 To the F complete	Σ	29b. Signature and title of certifier			\ -		License						(Month, E		
2	(5)		30. Name and address of person who				Print)	G553						3, 20	04	
	Sta	to	Dr. Fossett 31. Date filed (Month, Day, Year)		elcres	st Road	#160	Н	yatts	vil]	Le MD 2	0784	·			
	Registr		MAR 0 9 2004		K	Lan	2									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 11:00 BENNETTE March GLADYS C. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Co. HCR, Manor Care Wheaton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthpi Coun Mar 31, 1915 N. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TF Carolina 88 Mar Director 244-03-5246 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show Examiner must be notified at Yes 2□No Director Wheaton MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or itame 23a or 20902 U.S.A. 11901 Georgia Avenue Rm#234 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ent: If item 27 is marked other than "natural", or ita ury or other traumatic event, the Medical Examina 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Black þ 3 ☐ Widowed 4 € Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mitchell Oliver Maggie Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 Wysong Ct., Raleigh, N.C. Ernestine Durham -Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/11/04 Riverdale Crem. Riverdale, Maryland 4 Donation 21. Sign of Funeral Pervice Lice Robert O. Freeman Funeral Services, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only see cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Suddlen + so (ce disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be c þ 2DNo 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate 1 Yes 2€ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending s after decrei Alter by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospitel o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 31. Date filed (Month, Day, MAR 1 1 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

sician	Decedent's Name (First, Middle, I				2. Date of Death Month	Day Year	3. Time of Death
edical	Howard I	Baxter	4b Ciby	Town or Legation of Death	March	06 2004	
miner	5200 Block 56th			Town, or Location of Death attsville		4c. County of Dear	George's
ral		Sex 7. Age (In yrs. 12 M 2 F	last birthday) If Under	1 Year If Under 24 Hrs.	8. Date of Birth		hplace (Stete or Foreign
or	373-34-3364	1 ∆ M 2□F 35	Yrs. Months	Days Hours Min.	(Month, Dey,) July 27,		shington, DC
	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
jo	MD Prince 0						1 X Yes 2 □ No
Director	10e. Street and Number	eorge s	Landover 101. Zip	Code	100	g. Citizen of What Co	untry?
a D	1109 Nalley Rd.	#612		20785		USA	•
Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Deced	ent of Hispanic Origin? (Sporty Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
by Fu		1 ∏ Yes 2 XNo If Yes, Give	1 ☐ Yes 2		7110211, 0(0.)	Specify:	e, etc.
		Year or Dates:	16a Danadant's Have	I Convention		B]	ack
Completed	15. Decedent's (Specify only highest g	rade completed)	(Give kind of wor life. DO NOT us	I Occupation k done during most of works e retired)	ing 16	8b. Kind of Business/	inaustry
- mo	Elementary/Secondary (0-12)	College (1-4or 5+)		Collector		Privat	e
BeC	17. Father's Name (First, Middle, Las	st)			(First, Middle, Ma		
To	James	Baxter		Ma	ry	Bates	
	19a. Informant's Name/Relationship			(Street and Number or Rura			
	James Baxter/ Br		5410 Brenn	and the second second	-	ights, MD	20743
	20a. Method of Disposition 1X Burial 2 ☐ Cremation 3	□Removal from State 20b. P	lace of Disposition (Name emetery, crematory or of SURECTION			c. Location - City or Clinton, M.	
	*4 □Donation 5 □ Other (Spec	cify)					
	21. Signature of Funeral Service Lic	ansee	A STATE OF THE PARTY OF THE PAR	andover Rd.		ns Funeral r, MD 20	
	23a. Part1. Enter the disease, or co	molications that caused the death					Approximate
	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final			or dying, such as cardiac c	or respiratory arrest	le .	Interval Between Onset and Death
	disease or condition resulting in death)	a. Multiple Inj					
			derice or).				
Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Olsease or inju.)	Due to (or as a consequ	uence of):				
Examiner	that initiated events	c					
ŭ	resulting in death) Last	Due to (or as a consequ	uence of):				
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7	Physici /Medi		1. Decedent's Name (First, Middle, DORA BOLDEN	Last)			111100	10 0. 0.		2. Date of De Month MARCH	eath Da		3. Time of D	
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September 1	Funeral Director		247 52 0385 Usual Residence of Decedent	1 □ M 2/CX F	89	Yrs.	Months		Hours Min		ay, Year)	914 SOUT	place (State or antry) TH CARO	LINA
	r 28e-f ehow	irector	DC 10e. Street and Number		10c. Cit	WASHIN	ıÇT01	ip Code			10g. Ci	tizen of What Cour	NKYes 2	
036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or terms 23a or 28e-f show that the Medical Examiner must be notified at	by Funeral Director	1311 DELAWARE A 11. Marital Status 1 Never Married 2 Marrie XX Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U					Specify Yes or Norto Rican, etc.)		ITED STAT	can Indian, etc.	
9500-6121	within 72 ho ane. Ihan "naturi se Medical i	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5	5+)	(Give life. L	kind of w DO NOT	ual Occupation done duri use retired)	on ing most of wa	orking	16b. K	(ind of Business/In	dustry	
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	s 1 and 2 sho f Health and N item 27 is ma other trauma		19a. Informant's Name/Relationsh IRENE B. MOORE 20a. Method of Disposition		20h E		DEI	AWARE		W #S437	WAS	or Town, State, Zip	DC 2002	24
arimore,	Page Iment o tent: If jury or		XX Burial 2 ☐ Cremation 14 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service la	ecify)	0	emetery, cien SHINGTO	NAME :	other place) T. CEM	of Facility	13,2004	SU	ocation - City or To	ÍD.	
g D	permit Depart Import any in		23a. Part1. Enter the disease, or on shock, or heart failure. List of	complications that caused nly one cause on each lin	I the death	MA 43	ARSHA 308_5	LL'S E SUITLAN	UNERAL ID RD.	SUITLA	ND,	RYLAND, I MD 20746		en
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a conseq	uence of):	wè	Ca	selis	Vaso	G	Clista	Onset and De	ath
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икан жеск	n: The law r ficate has be r. page 2 sh	Completed	Hyper	2025)					1 □ Yes	osy ormed? 2 No	death?	npletion of caus	allable se of
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个	ر (ے) Sta	te	DR. AKPANS, 31. Date filed (Month, Day, Year)	MD 32 Registra		30	•	OSPITA	L DRIV	E CHEV	ERLY	Y, MD		
	Registr	ar	MAR 1 2 2	104	. k	hoo	1.1							

		1 - For State Registrar	State of Marylar	nd / Depa	artment rtificate	of Health and of Death	Mental Hy	giene 2	004	0	956
Physic /Med		1. Decedent's Name (First, Middle, Las Oliver Stoke					2. Date of De Month March	04,2004	Year	3. Time	of Death
Exami		4a. Facility Name (If not institution, give Mariner Health o				own, or Location of Dea	ath	Montgomery			
Funera Director	_		x 7. Age (In yrs. 84	last birthday) Yrs.	If Under 1 Months	Year If Under 24 Hr Days Hours Mir		10, Year) 3, 1919	9. Birthpl Count Illir	ace (State try) 1015	e or Foreigr
e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County Virginia Arlingt		rlingt					10		City Limits
h with th	Funeral Director	10e. Street and Number 900 N. Taylor St.	#1629		10f. Zip C			10g. Citizen of U.S.A.	What Count	try?	
III (Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tal Hygiene. dother than "naturel", or Items 23a or 28a-f show event, the Madical Examinat munition notified as	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1XIYes 2 No If Yes, Give Year or Dates: 194		nt of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	pecify Yes or No- o Rican, etc.) 14. Race - / Black, V Specify: V				
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		19a. Informant's Name/Relationship (T	•			Street and Number or F ker Ln.,Al					
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To the Hospitel or Attending Is within 24 hours after death. To the Funerel Director: Atler completely filled in by the funer	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	ffice	28f. Location (5 City or Tow	m, State)			mber,			
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To the Complet	Me	29b. Signature and title of certifier	M.D.			icense number		29d. Date signer			, 4
		30. Name and address of person who co	empleted cause of death (Item	1 23a) (Type, u cu St	Print)	ive #40	1 Roy	wile	mp i	2085	2
St Regist	ate	31. Date filed (Month, Day, Year) MAR 1 0 20	32. Registrar's Signa	ture &	Spa	eks					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Blakeig G Barke 4a. Facility Name (If not institution, give street and number) March 8, 10:35 P M Barke 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕮 F 54 Yrs. Washington, DC Director 220-54-1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28e-f show The Medical Expriner must be notified at 10d. Inside City Limits 1 Yes 2 □ No Director Montgomery Cabin John 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6916 Seven Locks Road 20818 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ŽÎNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Human Resources Administrator Universal Title 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Health and marked other: If it am 27 is marked other. Ouayle Smith Eleanor Goddard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6916 Seven Locks Road, Cabin John, Md. 20818 Dennis C. Burke/Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Gabriel's Cem. Potomac, Md. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licenses toms Ell 2222 Wisconsin Ave., NW., Wash., DC 20007 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non Small Cell 4months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) attending physician for use as the buria 68760 iclan/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) signed by the a d be detached f Physi 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1. Inpatient 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA of this 27. Manner of Death 28b. Time of 28c, Injury at Work? After t Certification: 28d. Describe how injury occurred Division or Attanding Injury 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the within 24 hours after deatl 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Levero 054378 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person why 6410 Rockledg Drive Saik 625 Bethesda Mei 20904 31. Date filed (Month, Day, Year)

MAR 12 2004 32. Registrar's Signature State oaks! Registrar

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State of Maryland / Department of Health and Mental Hygiene 2004 09562 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year CHRISTINE MARIE WEAVER BROOKS 2004 March 4, 4:35p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Chevy Chase

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Jan. 23,1957 9. Birthplace (State or Foreign Country) New Jersey **Funeral** 1 ☐ M 2 🖾 F 135-50-5421 Director 47 Usual Residence of Decedent 10b. County show 10c. City. Town or Location 10d. Inside City Limits other traumatic event, the Modical Examiner must be notified at 1 TYes 2 X No MD Prince Georges Bowie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or itama 23a 3230 Spriggs Requestway 20721 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) Chief Operating Officer School District 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfonso Weaver, Sr. Janet M. Melton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony J. Weaver/ Brother 13152 Rounding Run Circle, Herndon, Va. 20171 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 12 Burial 2 ☐ Cremation 3 ☐ Removal from State njury or 3/9/2004 4 □ Donation 5 □ Other (Specify) StonewallMemoryGardens Manassas, Va. 22. Name and Address of Facility Ames Funeral Home, Inc. 21. Signature of Funeral Service Licenses Bernard 8914 Quarry Rd. Manassas, Va. 20110 12 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 12/cma resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a y leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician a the burial-1 Due to (or as a consequence of) Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 5 ☐ Other (specify) ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 2 No 3 Probably 4 Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? раде 1 ☐ Yes 2 No or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide within 24 hours a

To the Funeral Completely filled I Hospitel t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m MND D22775 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5454 Wisconsin Avenue; Chevy CHase, MD Frederick G. Barr, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Oaka) Registrar 08

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State of Maryland / Department of Health and Mental Hygiene

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filed within 72 hours effer death with the Maryland Hygiene. Wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be multied at e. Completed by Funeral Director	10a. State 10b. County	10	c. City, Town or I	ocation				10d. Inside City Lim			
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ofter death v r flems 23 einer must Funeral	11. Marital Status	12. Was Decedent Eve		. Was Decedent of H If Yes, specify Cuba		(Specify Yes or No		- American Indian,			
s 1 and 2 should be filed within 72 hours efter death with the Marylan I Heath and Mental Hygiene. If Heath and Mental Hygiene. If The Trented other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be incitied at To Be Completed by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No				Jerto Hican, etc.)		, White, etc.			
ours e	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 No	Specify:		Specify:	BLACK			
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Health a more training the trai	LOURDES SIMON	/DAUGHTER	1911	EAST WES	T HWY.	#302. STI	VER SPRT	NG, MD. 2091			
permit. Pages 1 end Department of Health Important: If Item 27 any injury or other ti	20a. Method of Disposition	2	20b. Place of Disp	osition (Name of ematory or other place		Date		City or Town, State			
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permii Depar impor any in	MM. Cha	1 0	00001 C	HAMBERS F 801 CLEVE	UNERAL						
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Physician: rthis certific ral director,	1 ☐ Yes 2 🙀 No 27. Manner of Death		2 ☐ ER/Outpatie	IL SEL DOA	4 Li Nursing			(Specify HOSPICE			
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within 24 hours are to the Funeral Completely filled	00- 0-4°C										
within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, Medical Certification: To Be C	Check only 2 Medical Exam	rsician: To the best of my iner: On the basis of exam	knowledge, deat mination and/or in	n occurred at the time vestigation, in my opi	e, date and place nion, death occ	ce, and due to the courred at the time. d	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)			
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T V CO.	29b. Signature and title of certifier	^ ^/	11	29c. License	number	2	9d. Date signed (i	Month, Day, Year)			
1	·HU	V 10		D 3	5635		MARCH 9	9, 2004			
	30. Name and address of person who c	ompleted cause of death	(Item 23a) (Type,								
meson!	JOSEPH KAPLA	N, M.D.	5001 MUN	CASTER MII	L RD.	ROCKVILL	E, MD. 20	0855			
State	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature /								
Registrar	MAR 10 20	04 Banar	a B	sparks							

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** THOMAS GEORGE BOND, Sr. MARCH 2, P M 2004 3:37 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day, Year) | Min. (Month Day, Year) | 18 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1X M 2□ F 85 Maryland 212-14-5304 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other then "neturel", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 27 is marked other then "neturel", or Items 23a or 28a-f show treumatic event. The Medical Exercities in mast be notified at 1 ☐ Yes 2√2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12721 Atherton Drive 20906 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 XYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Year or Dates: 43-45 3 ∰Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Construction College (1-4or 5+) Elementary/Secondary (0-12) Self-employed Builder 6th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be h and Mental ? Charles E. Bond Grace Hackey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3640 Gleneagles Dr., Silver Spring, Patricia Young (Daughter) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Gate of Heaven Cem 3/13/04 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur SNOWDEN FUNERAL HOME, P.A. 22. Name and Address of Facility 246 N. Wash. St., Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, MYDCar Immediate Cause (Final disease or condition resulting in death) Physician /Medical ue to (or as a consequen 😕 🎵 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death ned by the a 9 Unknown signed t 23e. Did tobacco use contribute to the cause of geath? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 4 MUnknown cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25 I ☐ Yes certificate 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel sompletely filled 🕽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who EHE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 09565 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Yeer **Physician** 10. Casper W. Bohnenstiel March 2004 12:26 /Medical 4c. County of Deeth 4a. Fecifity Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 409-09-1666 Director 89 Sept. 9, 1914 Tennessee Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location r 28e-f show 10a. State 10b. County 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ref, or items 23a or Examiner must be 3300 Chiswick Court 20906 USA Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 132 Yes 2 1 No ff Yes, Give Year or Dates: WWII 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced naturel 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) event, the Medical 16b. Kind of Business/Industry United States Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ent; If Item 27 Is marked other than ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Air Force Armed Forces 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ Erwin J. Bohnenstiel Dorsey Whitmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gilliece/ Daughter 2713 Gillis Road, Mt. Airy, MD 21771 20b. Place of Disposition (Name of cometery, crematory or other place)
Gate of Heaven
Cemetery Date 20a Method of Disposition 20c. Location - City or Town, Stete permit. Pages to Department of Hisportant: If Ite any Injury or ot once. March 13, 1 ⊠Burial 2 □ Cremation 3 □ Removal from State A □ Donation 5 □ Other (Specify) 2004 Silver Spring, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring, 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Bile Leakage **Physician** 3 days resulting in death) /Medical Due to (or as a consequence of): Examiner Chronic Cholecystitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last 11 days Due to (or as a consequence of) Examiner The law requires that the death certificate be executed inding physicien and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 🖾 No 3 Probably 4 ☐Unknown <u>Abdominal Aortic Aneurysm</u> 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 1 Yes 2 X No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient Certification: To 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After fnjury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the trains of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43199 u ur March 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #200, Olney, MD 20832 Frank Lin M.D. 3416 Olandwood Court 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 12 oaks 2004 Registrar

			1 - For State Registrar		Marylar	nd / Depa <i>Cei</i>	artmen rtificat	t of H e of L	lealth a Death	and M		Reg	ene 20	004	- 4	<u> 566</u>
ı	Physici		Decedent's Name (First, Middle, Last Bathaung	at)							2. Date of Month March		Day 2004	Year	3. Time of 9:04	Death
	/Medio Examin		4a. Fecility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	of Death	rac or	4c. County of Death			10.04	
			15113 Joshua Tree	Road					tomac				Montg	У		
	Funeral		5. Social Security Number 6. S	ex SਹM 2□F	7. Age (In yrs.		Months Davs Hours Min (Month, Dav. Year)							Cou	place (State ontry)	or Foreign
	Director		Usual Residence of Decedent	33 Yrs. July 8, 19							, 15	920	Bur	ma		
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation								10d. Inside C	ity Limits
	a-f sh	ctor	Maryland Montgome	ry	Nor	th Pot	omac								1 🗆 Yes	2 <u>17</u> No
	or 28	Olre	10e. Street and Number				10f. Zip						. Citizen of \		-	
	s 23a	rai	15113 Joshua Tree		for English	10 110		878		:-0 (0-	4. W		nited			
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show among young you other traumatic event, the Modical Examinar must be notified at another.	by Funeral Directo	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes If Yes, Give	1 □Yes 257No			Was Decedent of Hispanic Origin? (Specify Yes or I Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No Specify:					No. 14. Race - American Black, White, et Specify: Asi			
Ö	2 hou	ted	15. Decedent's Ed							t at wad	una.	16	b. Kind of B	usiness/In	dustry	
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2	filed wi Hygien Sther th		-			Dipl	omat				(F)					
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lan.	2 sho		19a. Informant's Name/Relationship (Type, Print)									City or Town,	111	,	
	1 and Health em 27 ther to		Myint Bathaung/ Wife 20a. Method of Disposition	:	20h F	15113 Place of Dispo			Tree		, Nor	_	Cotoma c. Location -		2087	8 ′
100	Pages nent of h ant: If its		1 ☐ Burial 2XX Cremation 3 ☐		itate (Montg Montg	natory or o	ther plac	- :	larc	h 12,			-		
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury	(uerica or).								2	years	,		
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	at the dea by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐ Unkno	int at time of d wn	leath 5∟	Other (sp	ecity)				_			,	
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rds	quires n sign ald be	d by									1	☐ Yes	2 🗌 No	3 🗆 Prot	ably 4 🛣	Jnknown
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		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2	ER/Outpatien	it 3 DC	A Othe	ac:		n (Check or		e 6 □Oth	or (Coonit	5.1	
10	g Phys er this ieral di	n; T	27. Manner of Death	28a. Date o		28b. Time of Injury		8c. Injury Work	THE R. P. LEWIS CO., LANSING	_			injury occur		y/	
jo	Attending redeath.	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	, au ,	injuty	М		Yes 2 1	Vo						
Division	or Attenditer death Director: in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	286. Place	of Injury - At h g, etc. (Specii	ome, larm, str fy)	eet, lactory	r, office				n (Stree Town, S		er or Rura	i Route Num	ber,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	O	29a. Certifier 1X Certifying Ph	volsies: T- **	hant oft	andeder de d		-4.45					14:0:002:02			91
	24 hos	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exan	ysician: 10 the niner: On the ba and mann	sis of examina	ation and/or in	vestigation	at the tim , in my op	ie, date an pinion, deal	d place, th occurr	and due to ed at the tir	the caus ne, date	se(s) and ma and place,	and due to	tated. the cause(s)
	To the Hospital within 24 hours a To the Funerel I completely filled	Me	29b. Signature and title of certifier				290	. License	number			29d	. Date signer	d (Month,	Day, Year)	
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	<i>V</i> -	1	30. Name and address of person who Thaw Poon, M.D.,	completed cause	of death (Iter	п 23a) (Туре, St. Ра	Print) ul Pl	.ace,	#701	, Ba	altimo	ore,	MD 21	202		
	Sta		31. Date filed (Month, Day, Year)	32. Rg	gistrar's Signa	ature /		ack						-		-
3	Registr	ar	MAR 12 2	JU4 🥕	- July		140	CHR	2/							

			For State Registrar	State of Maryland	/ Depa	ertment of H tificate of I	ealth and Death	Mental Hyg	iene _{•g. No.} 20 (04 09567			
	Physici		1. Decedent's Name (First, Middle, Last) Elizabeth Bass					2. Date of Deal Marrch 5		3. Time of Death 2:10 P M			
<u>.</u>	/Medic Examin		4a_Facility Name (If not institution, give str 55555 Friendship Blv	d. # 312		4b. City, Town, or Chevy Ch	Location of Dea	ath	4c. County of				
	Funeral Director		003-44-8630	7. Age (In yrs. lass	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day,	Year) 9	D. Birthplace (State or Foreign Country) Iowa			
	he Maryland 28a-f show	ector	Usual Residence of Decedent	ery 10c. City, 1		cation 7y Chase 10f. Zip Code		1	0g. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes 2X No			
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23e or 28e-f show amy injury or other traumatic event, the Madical Examination and the notified at once.	Funeral Director	5555 Friendship Blv 11. Marital Status 1 Never Married 2 Married	d. #312 2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give			20815 ispanic Origin? (n, Mexican, Pue		United States 14. Race - American Indian, Black, White, etc.				
Maryland 21215-0036	within 72 hours iene. 'than "natural', ire Malical Exe	Completed by	3 Midowed 4 Divorced 15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	6a. Deced (Give life. I	dent's Usual Occupi kind of work done of DO NOT use retired	ation during most of w	orking	16b. Kind of Busin				
land 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last) Edward L. Hirsc		0001	WOIKE		ame (First, Middle, F rude Nird:	Meiden Sumame)				
, Mar,	and 2 sho ealth and I n 27 is me		19a. Informant's Name/Relationship (Type Harold Hirsch, Nep	hew		or Rural Route Number, City or Town, State, Zip Code) ,NW, Washington, DC 20002							
altimore,	tment of Herent: If Iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Sharon Memorial Park 03/08/04 21. Signature of Fun Service Licensee 22c. Location - City or Town, State 03/08/04 Sharon, MA 22. Name and Address of Facility Torchinsky Hebrew Funeral										
Ba	Depar Impor any in		21. Signature of Fun /al Service Licensee	Byle	25	4 Carrol	1 St., 1	W Washir	ngton, Do				
	Physician /Medical Examiner		shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	plications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Cerebrovascular Accident Due to (or as a consequence of): Severe Hypertension Approximate Interval Between Onset and Death 5 Days 40 Years									
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, it any feadons to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequer									
.O. Box 6	that the death certificed by the attending properties as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	23d. Date of Month								
<u>a</u>	w requires that been signed b should be deta		Part II. Other significant conditions conti	ributing to death but not resultii	ng in the u	nderlying cause give	en in Part I.			ute to the cause of death?			
Il Records,		Completed						24a. Was a autops perform 1 ☐ Yes 2	y prio ned? dea	re autopsy findings available or to completion of cause of oth? Yes 2 \(\sumbole \text{No}\)			
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Division of	E = 6	ıtlon: To	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation		b. Time of Injury	28c. Injun Work	the second second second second	Home 5 Neside	w injury occurred	(Specify)			
Divisi	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (Street and Number or Rural Route No City or Town, State)					
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier 1 1 Certifying Physi (Check only one)	cian: To the best of my knowle er: On the basis of examination and manner stated.	dge, death and/or inv	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manne ate and place, and	er as stated. I due to the cause(s)			
)	To the within To the comp	ž	29b. Signature and title of certifier	l'ada	D	29c. License	4	2	9d. Date signed (M	Month, Day, Year)			
	15		30. Mame and address of person who son	npleted cause of death (Item 23	(Type,	05(g)	/ massin	AND	Chou	Chace Mossil			
3	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	for some	porks	1	/10-0	Clievy	Crack 100 1			

			For State	State	e of Ma	aryland /		artment of tificate o			ental Hygi	ene	2004	09568
			1. Decedent's Name (First, Middle	e. Last)							2. Date of Deat	1	. 0 0 4	3. Time of Death
ť,	Physicia	an			-	1-					Month March	9, 2	Year	1:37a M
	/Medic		Mildred 4a. Facility Name (If not institution	C.		Baruch		4b. City, Town	n or Locat	tion of Death	Haren	7	ounty of Death	
	Examin	er							thes				ntgom	
1,000		70	Suburban H 5. Social Security Number	6. Sex		e (In yrs, last I	birthday)	If Under 1 Ye		nder 24 Hrs.	8. Date of Birth		9. Birth	place (State or Foreign
и 3(6).	Funeral Director			1 □ M 2 🖸	-	97	Yrs.	Months Day	ys Hou	urs Min.	8. Date of Birth (Month, Day, 7/12/	^{Year)} 1906	Cou	inois
- 49			577-60-7208 Usual Residence of Decedent								11121	1000		111015
	land DW		10a. State 10b. County			10c. City, To	own or Lo	cation						10d. Inside City Limits
	Many	ō	D.C. No.	ne		Wa	shi	ngton						1 X Yes 2 No
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	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show La Mydical Exertires mail be rigilled at	Funeral Director	11. Marital Status			Ever in U.S.	13.	Was Decedent of	of Hispani	c Origin? (Spe	cify Yes or No-	14.	. Race - Ameri	
	Iten Iten	-u	1 Never Married 2 Mar		ed Forces? Yes 2 🔼 I			f Yes, specify C			Rican, etc.)		Black, White,	
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an	iould be filed withir Mental Hygiene. Perked other then natic event, Le Mi	To Be	William Ha	erry Ca	adwal	ader			L	uLu B	lanche	Dow	ney	
2	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturat", or litems 23a or 28a-1 show aumatic event, II.a Mydical Examinat mad be retified at	-	19a. Informant's Name/Relations	ship (Type, Prin	t)	1	9b. Maili	ng Address (Stre	eet and N	umber or Rura	i Route Number,	City or T	own, State, Zij	p Code)
<i>10</i>	id 2 :		Karen Cohill	./Great	niec	e	441	5 Wood:	fiel	d Rd.	Kensi	ngto	n,MD	20895
ġ,	1 and Heelth iem 27	A 18	20a. Method of Disposition			20b. Place	of Dispo	sition (Name of			-		tion - City or T	
و	Pages nent of h ant: If ite		1 X8urial 2 Cremation		from State		•	natory or other ;	piace)	3/12/	0.4	2ron	twood	MD
ij	rtmer rtent njury		4 □Donation 5 □ Other (S	7.1		rt.			Idraes of F					
Baltimore,	permit. Pages 1 and 2 should Department of Heelth and Men Importent: If item 27 is marke any injury or other traumatic.		> Valy &	Krift	l .		P]	hilip 1 241 Co	D.Ri lumb	naldi ia Bl	Funera vd.Sil	al S /er	ervice Sprine	e,P.A. g,Md20910
2.45		į.	23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications t only one caus-	that caused e on each li	d the death. D	o not en	ter the mode of	dying, suc	h as cardiac o	r respiratory arre	est,		Approximate Interval Between
.70	Physician		Immediate Cause (Final disease or condition	(Cardi	ac as	vdo	le						Onset and Death 2. hrs.
	/Medical		resulting in death)	a.		a consequence								Z 111 S .
	Examiner		1755 325	b. I	Intra	crani	al h	nemmora	age					3weeks
		ē	Sequential vist conditions, if any, leading to immediate			a consequent								
	uted d ansit	Ē	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Cause (Disease) The contract of the contr										years	
Ć	icate be executed physician and s the burial-transit	Examiner	resulting in death) Last	D.	ue to (or as	a consequenc	ce of):							-
8760,	e be sicia e bur	dlcal		d										
89	ficate phy s the	ba										- T		
	death certific e attending p od for use as t	Ž	IF FEMALE: 23b, Was decedent pregnant			of pregnancy						230	d. Date of deliv	very
Вох	atter for u	clar	in the past 12 months?			2 ☐ Fetal dea tt time of death		∃Ectopic pregna ∃Other (s <i>pecify</i>					Month	Day Year
o.	the d	ysl	1 ∐ Yes 2 2 No 9	9□	Unknown									
م:	that the dei led by the a detached f	by Physician/Me	Part II. Other significant condit	ions contributin	g to death b	out not resultin	ig in the u	nderlying cause	given in l	Part I.	23e. Did tob	acco use	contribute to	the cause of death?
ds,	requires een sign hould be										1 □ Ye	s 2 🗆 i	No 3□Pro	bably 4XUnknown
Ö	w requires that s been signed to should be det	Completed									24a. Wasa	,	24h Were aut	opsy findings available
ĕ		ld n									autops	v l		on plation of cause of
=	Th ate pag	S									1 ☐ Yes 2	X No	1 ☐ Yes	2 🗆 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?		-		-			Place of Death	(Check only on	e)		
=	hysi this c	2	1 ☐ Yes 2 🛣 No	Hospital	1 XI Inpati			III 3 L DON			ne 5 Reside			ify)
u		e E	27. Manner of Death 1 ☐ Natural 5 ☐ Pend	ing 28a.	Date of Inju (Month, Da	ay Year) 28	b. Time o Injury	1	mjury at Work?		28d. Describe ho	w injury c	occurred	
sio	Attending r death.	Sati	2	tigation					1 🗌 Yes	-				- <u>-</u>
Division of Vital Record	pitel or Attencours after death ours after death lerel Director: filled in by the	ertification:		mined 28e.	Place of In building, e	ijury - At home itc. <i>(Specify)</i>	, farm, st	reet, factory, off	ice		28f. Location (St City or Town		Vumber or Rur	al Route Number,
	tel o rs aft el Di ed ir	Cer						30- 5- B			105 K			
	Hos Fur b	edical		il Examiner: On		of examination					and due to the ca ed at the time, d			
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certific	er /	2			29c. Lic	ense num	nber	2	9d. Date s	signed (Month,	, Day, Year)
	1		· Auce		7	MD			D3	7891			3/09/0	04
	26		00.11	n uho comein'-	d 02::00 = f	death (Item CC	a) /Tun-	Print)						
			30. Name and address of person						[.anc	#100	Rockvi	110	MA 20	1852
			31. Date filed (Month, Day, Yea,			trar's Signature		0	1	π403	1	-16	,174 20	032
	St Regist	ate rar	MAR 1	3 2004	Ban	مصي	19	Spor	Kal					

	,	1 - State Registrar	State	of Mary	land / Dep Ce	ertificate	Health and of Death	Mental H	ygiene Reg. No.	2004	09569	
Physici		Decedent's Name (First, Middle, Geral	, Last) d Larry	Bungai	rd			2. Date of I Month	Day	Year 2 00 4	3. Time of Death	
/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town	n, or Location of De	ath	4c.	County of Death		
		Union Hospital				Elkto				Cecil		
Funeral Director		5. Social Security Number 216-38-2845	6. Sex 1⊠M 2□F	7. Age (II	n yrs. last birthday Yrs.	Months Da			Day, Year)	Cou	place (State or Foreign intry)	
pu 🗼		Usual Residence of Decedent 10a. State 10b. County		10	c. City, Town or L	ocation					10d. Inside City Limits	
sho	5	Maryland Cecil	1	10	Elkton	OCATION					1 ⊠ Yes 2 □ No	
the N	Director	10e. Street and Number	<u>r</u>		DIRCOIL	10f. Zip Cod	Α		10g Citiz	zen of What Cou		
3a or	ā	252 West High	Stroot			2192						
death ms 2	Funerai	11. Marital Status	12. Was De		r in U.S. 13	. Was Decedent	of Hispanic Origin?	(Specify Yes or I		nited St 14. Race - Ameri	can Indian,	
parificiore, Marylatina Z.I.Z.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show may injury or other traumatic event, the Medical Exantractual by multiple and once.	by Fur	1 ☐ Never Married 2 ☒ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed F ed 1 Tyes If Yes, G Year or	2 XNo Sive		1 Yes, specify C	uban, Mexican, Pue No <i>Specify:</i>	erto Rican, etc.)		Black, White, etc. Specify: White		
atura cal E		15. Decedent'			16a. Dec	edent's Usual Oc	cupetion		16b. Kir	nd of Business/Ir		
Pin 7:	Completed	(Specify only highes: Elementary/Secondary (0-12)		(1-4or 5+)	(Giv life.	e kind of work do DO NOT use re	ne during most of w tired)	vorking			,	
a wit	P C	10			Se	lf-emplo	yed		В	arber		
d be file	Be (17. Father's Name (First, Middle, L	.ast)				18. Mother's N	ame (First, Midd	le, Maiden	Sumame)		
Vica ould i	၉	George Edward Bungard Eleanor May E										
Vicinity of the manufacture of t	7 3	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number,										
T and 1 and		Gerald L. Bund	gard/ser		20b. Place of Disc			, EIKTON		yland 21 cation - City or To		
Troil Hills		1 🖾 Burial 2 □ Cremation		1	Cherry I	matory or other i	Mai	cch 23,				
Dallillo bermit. Pages Department of mportant: #1 iny injury or ance.		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		1	Methodi	st_Cemet 22. Name and Ad	ery 200	04	Cher	ry Hill	Maryland	
Dermi Depa Impo any in		1	8.7	Dai	H	icks Hom	ne for Fur lockton St	nerals,	P.A.	Magazila	and 21021	
		23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that	caused the						, Maryla	Approximate	
Physician		Immediate Cause (Final disease or condition	only one cause on	1 t	Men	1.0	Infarct.	. 2-			Interval Between Onset and Death	
/Medical		resulting in death)	a. Due to	o (or as a co	onsequence of):	WHIN	- A Oct of	un		-	Immediate	
Examiner		Sequentially list conditions	b	15	CVD						years	
p is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a co	onsequence of):					10	/	
ecute and I-tran	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c	o (or as a co	onsequence of);							
icate be executed physician and sthe burial-transit	aiE	, and the second		(5. 45 4 5								
ficate ficate physis the	edicai		d									
ox certi	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o						2	3d. Date of delive	ery	
death death e atte	Physician/M	in the past 12 months? 1 Ves 2 No. 4 Pregnant at time of death 5 Other (specify)								Month Day Year		
by the state of the contraction	hys	9 Unknown	9□ Unk									
VICAL MECONICS, P.O. BOX of sicien: The law requires that the death certific certificate has been signed by the attending precior, page 2 should be detached for use as	by	Part II. Other significent condition In Sulin Desene	ent Dia	1 1	i	underlying cause F	given in Part I.				he cause of death?	
w raq	Completed	Cerial	Vacant	1	Pireuse			24a. Wa	is an	24b. Were auto	ppsy findings available	
The la	шо	- I - I I M CT RI	v a j cu j	ur y	132652			aut per	opsy formed?	prior to co death?	mpletion of cause of	
VICAL ician: 1 Sertificat ector, p	· o	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only	-/	1 🗆 Yes	2 L No	
ysici ysici is cer direc	To B	examiner? 1 ☐ Yes 2750 No	Hospital:	Inpatient	2 ER/Outpatie	ent 3 DOA	Other	Home 5□Re		☐Other (Specif	(v)	
LIVISION OF VICE THE PROCUES, F.C. BOX of To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig	(Ma	e of Injury onth, Day Ye	28b. Time Injury		njury at Vork? □ Yes 2 □ No	28d. Describe	e how injury	occurred		
LIVISION I or Attending after death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could n	ot be 28e. Plac	ce of Injury ding, etc. (5	- At home, farm, s				(Street and own, State)	Number or Rura	al Route Number,	
Dspital of hours a meral D		29a. Certifier 1 Certifying	g Physicien: To ti	ne best of m	y knowledge, dea	th occurred at the	e time, date and pla	ce, and due to th	e cause(s)	and manner as s	stated.	
the Ho nin 24 the Fu	ledical	one)	and ma	nner stated	amination and/or i		y opinion, death oc	curred at the time				
To To	Σ	29b. Signature and title of certifier	6			29c. Lice	ense number	4		signed (Month,		
		1 H Jan	cos, M	1)			15 717		Mar	-d 22	,2004	
4		30. Name and address of person v	vno completed ca	use of death	1/	+/:	= 1/ston	MD				
St	ate	31. Date filed (Month, Day, Year)	32.	Registrar's	Signature	spilel, t	-//(/ 0-1)	/	7			
Regist		f	MAR 2 9 2	№ 04	Francis Val	A Com	2012					

State of Maryland / Department of Health and Mental Hygiene, State AMEND ITEM #10d,11,12,13&20a PER FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28-**Physician** Month Year Ethel Bennett 2 22:20 04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SACKED HOSPITAL HEART CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F 214-52-1571 92 Director April 24, 1911 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "netural", or Itams 23a or 28a-f shov other treumatic event, the Medical Exembrat must be notified at 1 ☐ Yes 2 XXNo Director Maryland Allegany Frostburg 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 15600 Porter Cemetery Road N.W. 21532 death 1 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. ant: If item 27 is marked other than "netural", or Ita 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXI,No Specify Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip Knepp Bertha Burdock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Clifford Bennett Sr. -Son 15606 Porter Cemetery Road N.W. Frostburg Md. 21532 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State March 03, permit. Page Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Porter Cemetery 2004 Frostburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 8 E. Main 23a. Pagl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of) Examiner TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe CENAL LITHASIS 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an certificate has 1 Yes ₽No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 Yes 2 do 2 12 Inpatient 2 ER/Outpatient 3□ DOA filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 10 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospitel 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 023774 FEBRUARY 29, 2004 1good MI 30_Name and address of person who completed caus of death (Item 23a) (Type, Print) DRIVE CUMBERLAND MARYLAND 21502 AULT. LIVENGOOD MD 912 SETON 31. Date filed (Month, Pay, Year) WAR 0 2 32. Registrar's Signature State 2004 Senend Registrar

			For State Registrer	State of Mar	yland / De <i>C</i>	partment e <i>rtificate</i>	of Hea	ith a		Reg. No	2001		571	
	Physicia	an	Decedent's Name (First, Middle, Last)		11				2. Date of I Month	Da				
	/Medic	al	Maurice 4a. Facility Name (///pp///jst/usienng/ve		mpbell	4h City To	own or loca	ation of	March		004 . County of Dea		a. M	
	Examin	er	2601 Bell Pre		с ветт Р		ver St				ontgom			
	Funeral		Social Security Number 6. S		In yrs. last birthda	y) If Under 1	Year If t	Under 2	4 Hrs. 8 Date of I	Birth	9 Ris	thplace (State	or Foreign	
	Director		579 22 9817 ¹ / ₂	M 2□F	78 Yrs.	Months	Days H	ours	April	22 ,	1925Was	hington	, DC	
	pu .	-	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City. Town or	Location						10d. Inside C	City Limits	
	fanyla shor	5	MD. Prince G		Distric		hts						s 2 □ No	
	28a-	rect	10e. Street and Number			10f. Zip C	Code			10g. Cit	izen of What C	ountry?		
	3a or	0	7420 Marlboro Pik	.e			20	0747		Uni	ited St	ates		
	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	3. Was Decede	ent of Hispan	nic Origi	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Whi			
9	after or Ite	Fu	1 ☑ Never Married 2 ☐ Married	1 X Yes 2 □ No If Yes, Give		1 Yes 2		pecify:	r dento rnoan, etc.)		Specify: B1			
8	72 hours after death with the Maryland neturel; or Items 23a or 28a-f show deal Examiner must be notified at	d b	3 Widowed 4 Divorced	Year or Dates:	1 40 0					10) 16				
7	n 72 I	Completed by	15. Decedent's Edu (Specify only highest grad	e completed)	16a. De (Gi	cedent's Usual ve kind of work DO NOT use	Occupation done during retired)	g most o	of working	16b. K	ind of Business	industry		
72	withi iene. r than	omp	Elementary/Secondary (0-12)	College (1-4or 5+) none		1 Capta				Army	& Nav	y Club		
Þ	e filec Il Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)				18.	Mother'	s Name (First, Midd					
<u>Jar</u>	uld by Menta Menta rrked rtic e	To E	Joseph Campbell				Ac	ddie	Davis					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23a or 28a-f show apprintury or other treumatic event, the Medical Exertine must be notified at once.		19a. Informant's Name/Relationship (Ty Ron Allen/ Nephew						or Rural Route Num NW #307				008	
<u>∞</u>	l and fealth im 27 her tr				200 20b. Place of Dis			Г.,	Date		ocation - City or			
Baltimore,	in of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		cemetery, c	rematory or oth	er place)	0	3/09/04					
Ħ	it. Pa intmer intant injury		' 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Dineral Service Licens	99 ()	Harmony	22. Name and	- Anna Carlotte			-	lover, 1			
Ba	permi Depar Impo any ir		1 heres	5.01	W				John T. et,N.E. W					
		-	23a. Part1. Enter the disease, or complete shock, or heart failure. List only or	ications that caused	e death. Do not						gron, D.	Approxima Interval Be	ite	
	Prysician		In(mediate Cause (Final disease or condition	Pneumon	i a							Onset and	Death	
	/Medical		resulting in death)	Due to (or as a c										
	Examiner		Sequentially list conditions.	CVA/Str										
	ed ssit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury	Due to (or as a c	consequence of):									
	xecuti and	Examine	that initiated events resulting in death) Last	Due to (or as a	consequence of):									
8760,	death certificate be executed e attending physician and of for use as the burial-transit	icai E		4										
687	ificate g phy as the	ed												
Вох	death certifica attending ph d for use as th	M/u	230. was decedent pregnant	3c. If yes, outcome of 1 ☐ Live birth 2 (3 □Ectopic pred	олапсу				livery			
	ne deat the att	sicia	in the past 12 months? 1 Yes 2 No	4 Pregnant at tin		Other (spec					Month	Month Day Year		
P.0	that the de ed by the detached	Physician/M	9 Unknown		ant societies in the			Dort	220 Die	d tobacco i	use contribute to	n the nause of	death?	
ds,	es be	þ	Part II. Dther significent conditions con Dementia	inputing to death but i	tot resulting in the	dridenying cac	use giveri iii	raili.		Yes 2		robably 4		
Vital Records,	w requir been si should	Completed							24a. W	e an	24h Wara a	utopsy findings	available	
Rec	The lay ate has page 2	m	Hypertension						— au	topsy rformed?	prior to death?	completion of	cause of	
ā	icien: T certificate rector, pa	C	25. Was case referred to medical				26	Place o	1 ☐ Yes		1 ☐ Yes	28 No		
>	Physicien: this certific ral director,	o B	examiner?	lospital: 1 Inpatient	2 ER/Outpat	ient 3 DOA	Othor		sing Home 5 ☐ Re		6 □Other (Spe	cify)		
υof		T:uc	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(eer) 28b. Time		c. Injury at Work?		28d. Describ	e how inju	ry occurred			
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation			М	1 🗌 Yes	2 🗌 N						
Division	after death after death Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, 'Specify)	street, factory,	office			(Street an own, State	nd Number or R s)	urai Houte Nun	nber,	
נ	urs urs ille		29a. Certifier 1⊠ Certifying Phy	sician: To the best of	nv knowledge de	ath occurred at	t the time d	ate and	place, and due to th	e causa(e)	and manner as	s stated.		
	24 hos Prun Petely	edical		ner: On the basis of ex and manner state	camination and/or								s)	
	To the Hosp within 24 ho To the Fune completely f	Me	29b. Signature and title of certifier			29c.	License nun	mber	· · · · · · · · · · · · · · · · · · ·	29d. Da	te signed (Mon	th, Day, Year)		
)			Vin	Detty u.b		D0	06055	2		Marcl	h 3, 20	Ò4		
	(5)	(30. Name and address of person who c	emple fed cause of deal	(Item 23a) (Typ	e, Print)								
			19703 Executiv	e Park Circ	cle Ger	mantown	, MD	_208	374					
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2004	2. Registrar's	Signature A	alle.								

	1	For State Registrar	State of Maryla	•	artment of F			giene Reg. No. 20 (04 0957
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last, Robert W.	Colbert	III			2. Date of Da Month 3	Day Ye	4 5:12 A'
Examine	_	4a. Facility Name (If not institution, give 6259 Fernwood Tern			4b. City, Town, o	or Location of Deat lale	h	4c. County of E	e George's
uneral rector		5. Social Security Number 6. Security Number 18		s. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da 12 1	th y, Year) 9.	Birthplace (State or Forei Country) ashington, D(
B-f show		Usual Residence of Decedent 10a. State 10b. County MD Prince Ge		City, Town or Lo Riverda					10d. Inside City Limi
3a or 28	Director	10e. Street and Number 6259 Fernwood Ter	race		10f. Zip Code 20737			10g. Citizen of What	Country?
	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Airf		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Race - A Black, V Specify:	Merican Indian, White, etc. Black
Medical	Completed	15. Decedent's Edu (Specify only highest grad	le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of Busine	ess/Industry
event, the	Be	17. Father's Name (First, Middle, Last)	2 yrs	Mecha	nic Supe	18. Mother's Na		Private Maiden Surname)	
raumatic ever	ဥ	Robert W. Colber 19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Street	Gloria and Number or Re	Chiches	ster or, City or Town, Stat	e, Zip Code)
ther tra		Melva Colbert/Wif		1	Fernwood	Terrace	Riverda:	le, Maryla	
any injury or other tr		1 ☐ Burial 2 ☒ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crea	natory or other pla	2/1	0/04	20c. Location - City Riverdale	Maryland
any inj once.		21. Signature of Funeral Service Licens	0					ins Funera er, Maryla	al Home
dical miner transit	i Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Liner underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.	equence of):					
or use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	tal death 3	Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
be o	þ	Part II. Other significant conditions co	ntributing to death but not re	esulting in the u	nderlying cause gr	ven in Part I.			e to the cause of death? Probably 4 \(\sum \text{Unknown} \)
s certificate has been s lirector, page 2 should	Completed						24a. Was autop perio 1 🗆 Yes	rmed? death	
rector	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∑ No	Hospital:		Ott		ath (Check only o		
funeral d	ation: To	27. Manner of Death 13 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Inju	4 Li Nursing F		dence 6 Other (S	Брөсіту)
ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office		28f. Location (S City or Tox	Street and Number or vn. State)	Rural Route Number,
To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exami	sician: To the best of my kiner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the to vestigation, in my o	me, date and place opinion, death occu	e, and due to the durred at the time, d	cause(s) and manner date and place, and c	r as stated. due to the cause(s)
Comp	×	29b. Signature and title of certifier	expla	M	29c. Licens	5 6 70		29d. Date signed (Ma 3 - 9-	onth, Day, Year)
77 1 1	t	30. Name and address of person who ca	ompleted cause of death (It	em 23a) (Type.	Print\				

		•	1 - For State Registrar	State of Ma	ryland /		rtment tificate			nd Mer		giene Reg. No.	200	4 09	571
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	CYMBA	LIS	TY					Date of Dea Month	Day De	2 04	3. Time of De	
	Examin	er	4a. Facility Name (If not institution, give Holy Cross Hos	pital			Si	lver	Spri	ng		1	County of Deat	ery	
. 5	Funeral Director		5. Social Security Number 6. Se 049-24-9545	х 7. Age	(In yrs. last i	birthday) Yrs.	If Under Months	Days	Hours	Min.	Date of Birth (Month, Day 4-14-2	, Year)	Co	hplace (State or Fo ountry) aine	oreign
	the Maryland	Irector	10a. State 10b. County MD Montgomer 10e. Street and Number	у	10c. City, To			Code				10g. Citiz	zen of Whai Co	10d. Inside City L 1 다 Yes 2년 untry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itama 23a or 28a-f ahow amy injury pro other traumatic avent, the Macical Examinar must be notified at once.	by Funeral Director	11715 Owens Glen 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Way 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Deced f Yes, spec	ent of His ify Cubar		n? (Specify Puerto Ric	/ Yes or No- an, etc.)		14. Race - Ame Black, Whit		
Maryland 21215-0036	d within 72 ho giene. er than "natur i the Madical.	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	ication le <i>completed)</i> College (1-4or 5- 2	+)	(Give life.	leni's Usua kind of wor DO NOT us laker	i Occupa k done di e retired)	tion u <i>ring</i> m <i>ost</i> o	of working		16b. Kir	nd of Business	Industry	
yland	ould be file Mental Hy arkad oth	To Be (17. Father's Name (First, Middle, Last) Ivan Walnicky						Sophi	a Dro	homir	ecky			
, Mar	and 2 sh ealth and m 27 is m nar traum		19a. Informant's Name/Relationship (T) Ksenia Kuzmycz - I		1	1715	0wen	s Gl	en Wa	y Nor	th Po	toma	C, MD 2	0878	
Baltimore,	artment of H ortant: If its injury or oth		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		20b. Place ceme St.	Andr	ew's	Cem.	3	Date 3-12-0 Hina	04	S. E	cation - City <i>or</i> Boundbro li F. H	ook. NJ	
Ba	Degrand and and and and and and and and and		23a. Part 1. Enter the disease, or comp	lications that caused	the death. D	1	1800 1	New I	lampsh	nire A	Ave. S	ilve		ng, MD 20 Approximate Interval Between	
8760,	Physician // Medical Examiner white private white private white private white Icai Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cardior Due to (or as a Due to (or as a Corganic Due to (or as a	espira consequence ion pro- consequence brain	neumo	nia						1	Onset and Dea	en ith	
.O. Box 68	The law requires that the death certificate be executed tile has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 1 9 □ Unknown	2 Fetal dea		Ectopic pro					2	3d. Date of del	ive ry D a y Yea	ir
ecords, P.	quires that n signed by	by	Part II. Other significant conditions co	ntributing to death bu	it not resulting	g in the u	nderlying ca	ause give	n in Part I.				_	the cause of deat	
\mathbf{x}	The law requinate has been sipage 2 should la	Completed									24a. Was a autop: perfor 1 Yes	sy med?	24b. Were au prior to death?	topsy findings ava completion of caus	ulable se of
Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	p+		heck only or				
oţ	Jing After fune	ation: To	1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	1 ☑ Inpatier 28a. Date of Injur (Month, Day	y 28t	Outpatier Time of Injury		8c. Injury Work	4 L Nurs	28d	5 ∐ Resid . Describe h		Other (Spectroscopies)	cify)	
Division	To the Hospital or Attandi within 24 hours after death. To the Funaral Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ry - At home, :. (Specify)	, farm, str	eet, factory	, office		28f.	Location (S City or Tow			iral Route Number	ç
	the Hospital nin 24 hours a the Funaral I npletely filled	edical	(Check only 2 Medical Exam	rsician: To the best of iner: On the basis of and manner sta	examination	dge, deat and/or in	vestigation,	in my op	inion, death	place, and occurred	at the time, o	ate and	place, and due	to the cause(s)	
)		Σ	29b. Signature and title of certifier	nce rele	W	2	290	License	number 5615	3	2	29d. Date 3	signed (Monti	n, Day, Year)	
	6		30. Name and address of person who c	ompleted cause of de	eath (Item 23	a) (Type,	Print)	Kris	tie N	lowak,	M.D.	~9.	0		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 11 200	32. Registra	ar's Signature	B	Spo	uls	4 0		X C)] [

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 01 2004 12:23 PM CONNER-SIEKANOWICZ ALEXANDER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring 8. Date of Birth (Month, Day, Yea Feb. 29, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 12XM 2□ F Director None Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shorother traumatic event, the Machal Examinar mast be notified at 1 ▼Yes 2 No Maryland Silver Spring Montgomery Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20905 434 Firestone Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 図 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) N/AInfant 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Toni Υ. Conner Siekanowicz Andrew John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 434 Firestone Drive, Silver Spring, Maryland 20905 Toni Y. Conner/Mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H
Important: If ite
ony injury or of
once. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Brentwood, Maryland Ft. Lincon Crematory | 03/08/2004 A □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service Licenses HINES-RINALDI FUNERAL HOME 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Respusitory feulure **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** acidos reterbolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Grade III Intraventricular homorrhage Box 68760. -23 weeks gestation Completed by Physiclan/Medical prematurity IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Dav 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐Yes 2 ☐ No 0 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 3 Probably 4 Unknown 1 Tyes 2 No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page ; 1 Yes certificate 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2♥ No N☑ Inpatient 2 ☐ ER/Outpatient 2 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Menner of Death Certification: After 5 Pending investigation Natural ospital c.
44 hours after dea.

val Director: Afr 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hours.
the Funeral Directory filled in 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 Dhawn C D046711 March 1, 2004 Keeriean, nel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon Kiernan, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks 08 2004 Registrar

Physici	an	1. Decedent's Name (First, Middle, Last)		Langu				2. Date of De	ath Da	y Year	3. Time of Dea
/Medio		4a. Facility Name (If not institution, give :		CB 11/54	4b. City	. Town, or I	Location of Dea	Feb		County of Deat	
CXAIIII	ICI	Suburban Hospital				nesda				lontgome	
Funeral Director		5. Social Security Number 6. Sex X 212-88-0462	7. Age (In)	yrs. last birthday Yrs.	/) If Unde Months		If Under 24 Hrs Hours Min	(Month, Da	th y, Year,	9. Birt Co .976 Mar	hplace (State or Fountry)
3		Usual Residence of Decedent 10a, State 10b, County	10c	. City, Town or L	ocation						
"natural", or itema 23a or 28a-f show edicul Exaculari must be recilified at	o	,			Location						10d. Inside City Li 1 ☐ Yes 2)
7.28a	by Funeral Director	Maryland Montgomer	y <u> 1</u>	Potomac	10f. Zi	p Code			10g. Ci	tizen of What Co	ountry?
23a o	ai D	6 Eldwick Court				20854			U	S.A.	
tema M. T.	nner		 Was Decedent Ever i Armed Forces? 	in U.S. 13.	. Was Dece If Yes, spe	dent of His	panic Origin? (9 , Mexican, Puer	specify Yes or No to Rican, etc.)	-	14. Race - Ame Btack, White	
l', or l	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ X No If Yes, Give Year or Dates:		1 🗆 Yes		Specify:			Specify:	
atura cut E	ted	15. Decedent's Educ	cation	16a. Dece	edent's Usu	ial Occupat	ion		16b. K	(ind of Business/	ite Industry
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vent, It.a Mu			4	Biol	logist					Science	e
ed oth	Be	17. Father's Name (First, Middle, Last) Raymond Coleman / F	other-			1		ne (First, Middle,	Maider	Sumame)	
mark	To	19a. Informant's Name/Relationship (Ty)		19h Mail	ling Addres	s (Street an		a Royen	ne City	or Tourn State 7	Vin Code)
27 is r trau		Raymond Coleman /	Father								.ip C009)
Item othe	1 30	20a. Method of Disposition	20	b. Place of Disp cemetery, cre	osition (Na	me of	FOLOMA	Date		ocation - City or	Town, State
1 in 1		1 Burial 2 □ Cremation 3 □ R Other (Specify)	omovan nom State	King Dav			- 1	/2004	a11	s Church	n, VA
opportant: If Item 27 is marked other than any injury or other traumatic event, ILA M ODGS.		21. Signalure of Funeral Service License	97					nes-Rina			
5 5 3		Jan F. 7/W	lst.					e Ave. S		er Sprin	ng, MD 20
sician		23a. Part 1. Inter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each line.			de of dying,	such as cardia	or respiratory ar	rest,		Approximate Interval Betwee Onset and Dea
ledical aminer		resulting in death)	Due to (or as a con-	sequence of):							1.0 1.0
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physician and the burial-transit	Еха	that initiated events c resulting in death) Last	Due to (or as a cons	sequence of):							
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ched	ysic	1 Yes 2 No 9 Unknown	9 Unknown	ordeath 5t	Other (s)	oecity)					
signed by the a Id be detached f	by Ph	Part II. Other significant conditions con	tributing to death but not	resulting in the u	underlying o	ause given	in Part I.	23e. Did to	bacco u	use contribute to	the cause of deat
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ctor: After y the funera	tion	1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time o Injury	M A	28c. Injury a Work? 1 □ Ye	s 2 □ No	28d. Describe h	nujni wo	y occurred	
Director: in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	it home, farm, st ecify)			20.10	28f. Location (S City or Tow	itreet an n, State	d Number or Rur	ral Route Number,
To the Funeral Director: Atter this certific completely filled in by the funeral director.		(Check only 2 Medical Examin	ician: To the best of my ler: On the basis of exam	knowledge, deat	th occurred	at the time,	, date and place	, and due to the o	ause(s)	and manner as	stated.
o the	Medical	29b. Signat re and title of cartifier	and manner stated.			c. License r				e signed (Month,	
1 8		hunt	_			mo	625	2	-	,	_
0		30. Name and address of person who cor	Inleted cause of death (tem 23a) /Tuna	Print	2	011		بشما	25 27,	2004 2014
10											

State of Maryland / Department of Health and Mental Hygiene 2004 09577 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARCH 4, 2004 10:43P EDITH CHAIKIN BELLA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HOLY CROSS HOSPITAL MONTGOMERY SILVER SPRING If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🖫 F YES Director 152-20-6458 76 OCT. 4, 1927 PENNSYLVANIA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f show artment of Health and Mantal Hygiene.
ordent: If item 27 is marked other than "naturel", or items 23a or 28e-1 show injury or other traumatic event, it a Maride Event and the traumatic event. 1 ☐ Yes 2 ☐ No MONTGOMERY SILVER SPRING MARYLAND Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES OF AMERICA 10613 STONEY HILL COURT 20901 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 HUMAN RESOURCES DIRECTOR ENGINEERING MANUFACTURER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be RALPH SAYLAR GOLDIE FISCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORI CHAIKIN - DAUGHTER 1933 HICKORY HILL LANE, SILVER SPRING, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State KING DAVID MEMORIAL GARD. 03/07/04 FALLS CHURCH, VA * 4 □Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee EDWARD SAGEL FUNERAL DIRECTION, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ACUTE INFERIOR WALL MYOCARDIAL INFARCTION 2 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical phys. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? HYPERTENSION autopsy performed? 1 TYes 2**7** No **2**√ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 📉 No 1 XInpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XIatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5186 Den 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -eorgia Ave #308, Silver Spring Lieberman MD, 10336 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

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souls

		Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of H	lealth and Death	R	eg. No.	004	00010
Physi	cian	Decedent's Name (First, Middle, Last)	1.0				2. Date of Dear Month	Day	Year	3. Time of Death
/Med	dical	Marjorie Bassfor 4a. Fecility Name (If not institution, give si		-	4b. City, Town, or	Location of De	March 1		ty of Deeth	8:55 a ^M
Exam	iner	Prince George's Ho		r		verly		1		eorge's
Funera	al	5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H Hours M				lece (State or Foreign
Directo		4//-14-300/	M 2X)F 81	Yrs.	MONITS Days	riours	Feb. 7,	1923		esota
and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
Maryl -f sho	tor	MD Prince G	George's N	ew Car	rollton					X□Yes 2□No
h the r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	f What Cour	itry?
th wit	Funeral Director	7313 Gavin Street			207			US		
or dea	uner	Tr. Wartar States	Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		ace - Americ ack, White,	
rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		I ☐ Yes 2 ☒ No	Specify:		Spec	ity: Wh	ite
2 hour	ted	15. Decedent's Educ	ation	16a. Deced	ient's Usual Occupa	ation		16b. Kind of	Business/Inc	dustry
And P	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	kind of work done of OO NOT use retired	during most of v f)	vorking			
ed will	Completed	12		He	omemaker		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Own		
De fil	Be	17. Father's Name (First, Middle, Last) Robert Bernard Goe	bel				_{lame (First, Middle, I} Butterfie		ame)	
ife, MidI yidilly 2.12.13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic svent, the Midical Examinational Lear clitholal	은	19a, Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street a		Rural Route Number		n, State, Zip	Code)
and 2 sealth arm 27 is		Nancy B. Yannayon					Mechanic			20659
of Health of Hem 27 is rother tra	-	20a. Method of Disposition		Place of Dispo	sition (Name of natory or other plac	e)	Date	20c. Location	n - City or To	wn, State
Page Page Thent ant: H		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)		ington N	at. Cemeter	y 3	/8/2004			
Deficient Pages 1 Department of Pimportant: # Ite	ouce.	21. Signature of Funeral Services License	Pay				Basch's Fu e., Hyatt			
Physicia /Medica Examine	al	23a. Part1. Enter the disease, or complic shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Elevo	2.22		dial Infi		ion	Approximate Interval Between Onset and Death
COIGS, P.O. BOX 60/00, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	,						
the death certifi y the attending is the death of the dea	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgpths? 1 □ Yes a No 9 □ Unknown	Sc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	ıl death 3 [Ectopic pregnancy	,			ate of delive fonth	ery Day Year
The law requires that the take has been signed by the bage 2 should be detache	þ	Parll. Other significant conditions con 1-1/1 Der tein 5:0	-	ulting in the u	nderlying cause give	en in Part I.	23e. Did to			ne cause of death?
TECO The law re te has bee age 2 sho	Completed						24a. Was a autops perform	ned?		psy findings available mpletion of cause of
VICAL ician: Tentificat ector, p	BeC	25. Was case referred to medical				26. Place of D	Death (Check only or			
Phys rthis	on: To	examiner? 1 Yes No	ospital: Inpatient 2 28a. Date of Injury (Month, Day Yeer)	ER/Outpatier 28b. Time of Injury	28c. Injun Work	y at k?	g Home 5 Reside			1)
DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str (y)		Yes 2 □ No	28f. Locetion (S City or Town		nber or Rura	l Route Number,
ths Hospital nin 24 hours a ths Funaral (edical C	29a. Certifier Certifying Phys	lician: To the best of my knoter: On the basis of examination and manner stated.	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death o	ace, and due to the cocurred at the time, d	ause(s) and r ate and place	manner as si e, and due to	ated. the cause(s)
To the vithin 2 To the complete	Med	29b. Signature and title of certifier			29c. Licens			9d. Date sign	ned (Month,	Day, Year)
F S F S		17 Sarr	4 931		DH	804	h	31	011	2004
2 (10)		30. Name and address of person who co		n 23a) (Type.	Print) C	reen	best	M	D.	
	State	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature	. ·					
Regi	strar	MAR 0 8 2004	Distre A	6004	W					

DHMH 17 Rev 1/2001

ORIGINAL

4			1- For State of Maryland / De Registrar	partment of Health and Me ertificate of Death	ental Hygie Reg.	ne 2004 09579
47E	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
d.	/Medic	al	Doris K. Cannady	4b. City, Town, or Location of Death	March	1 2004 11:23 A ^M 4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and number)			-
			6141 Gate Sill 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Columbia If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Howard 9. Birtholace (State or Foreign
	Funeral Director		577-40-5824 1 M 2 XF 73 Yrs	Months Days Hours Min.	(Month, Day, Ye	1000 1
			Usual Residence of Decedent		sep. 13.	1930 Wash., DC
	ylanc ylanc		10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	Mar med	itor	Maryland Howard	Columbia		1 ∑Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	th wi		6141 Gate Sill	21045		United States
	sems sems	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, Whitereice an
36	filed within 72 hours after death with the Maryland Hygiene. ther than 'naturel', or Items 23a or 28e-f show int, the Maulcal Examination to the matthed at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give	1 ☐ Yes 2 No Specify:		Specify: American
21215-0036	hour:	å p	3 ★ Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. De	cedent's Usual Occupation	161	. Kind of Business/Industry
5	n 72 n "nai	Completed	(Specify only highest grade completed) (G	ive kind of work done during most of working	g	S. Kind of Business/industry
72	with ene. thar	E	Elementary/Secondary (0-12) College (1-4or 5+) 12th	Procurement Analyst		Government
ğ	Hyg other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		
au	lid bar	To B	George W. Gantt, Sr.		Cather	ine Curry
Maryland	should have	Γ.	19a. Informant's Name/Relationship (Type, Print) 19b. M.	ailing Address (Street and Number or Rural	Route Number, C	ity or Town, State, Zip Code)
Σ	alth alth		Marcus J. Cannady, III - Son 6	141 Gate Sill, Colum	bia, MD	21045
Baltimore,	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or items 23a or 28e-1 show any injury or other traumatic event, the Madical Extractive must be mailted at ance.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	sposition (Name of Da crematory or other place)	ate 200	c. Location - City or Town, State
Ĕ	Pagnent ment: I		1	Heaven Cem. 3/5/2	.004	Silver Spring, MD
a	porting in the light		21. Sign, ure of Funeral Service Licensee	22. Name and Address of Facility St	ewart Fu	neral Home
_	202 2 2	V	John I. Slewart III	4001 Benning Rd.,		sh., DC 20019
			23a. Part . Enter the disease, or complications that caused the death. Do not shock or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or	respiratory arrest	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	rosenche Arra	ays 6	28 Care 5 4 K
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		•	
۱	LXummer	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):	hotnich Armi e hypertense brenies	3	4 117
	ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Inenies		9 11 1
	and and II-trar	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):	17 / 50 / /		0 11 -
8760,	cate be exacuted physician and the burial-transit	ie H				
687		edicai	d.			
Box	Attending Physician: Tha law requiras that the death certif r death. sctor: Atler this certificate has been signed by the attending by the this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- M-		23d. Date of delivery
ň	death e atte d for	icia	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other <i>(specify)</i>		Month Day Year
0	t the by the	hys	9 ☐ Unknown 9 ☐ Unknown			
ď.	s tha	y P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
Records,	w require been sig should b				1 🗆 Yes	2 ☐ No 3 ☐ Probably 4 ☐ Unknown
ဝင္	aw re	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
č	Tha I	ĕ			performed	? death?
ita	sian: artifica ctor,	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
Ž	hysic his ce I dire	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa	The second secon	e 5 Residence	e 6 Other (Specify)
ם	ng P Viter t unera	ë.	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	y Work?	8d. Describe how i	njury occurred
sio	tendi leath. tor: A	cati	Accident investigation	M 1 Tes 2 No	2/ 1 /2-	
Division of Vital	l or At after d Direct Direct I in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Town, S	t and Number or Rural Route Number, tate)
	pital ours a aral [ပိ	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, do	noth coolered at the time, date and place, as	ad due to the sauce	o(s) and connect on stated
	To the Hospital or Attending Physician: Tha lav within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	edical	29a. Certifier (Check only one) (Check one) (Check only o	investigation, in my opinion, death occurred	d at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To tha complet	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
	12		> S Mann	730641	N	larch 4 2004
1	2/0		30. Name and address of person who completed caush death (Item 23a) (Tv	De, Print)	-	2 11 11
	4		30. Name and address of person who completed causand death (Item 23a) (Tyles)	Erdman Ave	nue 13	alnmer Mayland
	Sta Registr		31 Date filed (Manth, Day Year) MAR 32. Registrar's Signature			777

State of Maryland / Department of Health and Mental Hygiene?

09580

1-	For State Registrar			
1. D	ecedent's Name	(First,	Middle,	Last)

Certificate of Death

2. Date of Death 3. Time of Death

Physician /Medical Examiner

ROBERT WILLIAM COOMBS 4a. Facility Name (If not institution, give street and number)

Month 4b. City, Town, or Location of Death

1946 March 17 2004 4c. County of Death

Funeral 001-46-9730 Director

Director

Funeral

ģ

Completed

Be

hours after

Health and Mental Hygie em 27 is markad other

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

attending physician

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signed by the at d be detached fo

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in by the funeral

pelli 24 hours a

After

Director

death.

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To the within 2 To the

certificate be executed

P.O. Box 68760

Records,

Division of Vital

Examiner

Physiclan/Medical

Completed by

Be

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Certification:

Medical

Baltimore, Maryland 21215-0036

Fort Washington Hospital Center 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number

Fort Washington

Prince Georges

10a. State

№ M 2□ F

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR. 26, 1956

Birthplace (State or Foreign Country)

Usual Residence of Decedent in than "natural", or Items 23s or 28s-f show the Modical Examiner must be notified at

10b. County CHARLES

WALDORF

10d. Inside City Limits 1 ☐ Yes 2√2 No

Approximate Interval Between Onset and Death

Year

MARYLAND 10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

2308 AVALON COURT

12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1 9 7 3 - 9 5

College (1-4or 5+)

MO0479

20603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

U.S.A. 14. Race - American Indian, Black, White, etc.

11. Marital Status

1 Never Married 2 Married

1 ☐ Yes 2√2 No Specify: Specify: WHITE

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

47

10c. City, Town or Location

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12

RET.PETTY OFFICER

U.S.COAST GUARD U.S.GOVT.

17. Father's Name (First, Middle, Last)

RAYMOND COOMBS

18. Mother's Name (First, Middle, Maiden Sumame) ALICE E.MILBURY

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

KATHRYN COOMBS-SPOUSE

20b. Place of Disposition (Name of cemetery, crematory or other place)

2308 AVALON CT. WALDORF, MARYLAND 20603 20c. Location - City or Town, State

20a Method of Disposition NDBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

HOLY CROSS CEM.

3-27-04 AKRON, OHIO 2. Name and Address of Facility PAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646

21. Signature of Fuperal Service Licenses hehore

ant). Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Arteriosclerotic Cardiovascular Disease

Immediate Cause (Final resulting in death)

Sequentially list conditions, if any, leading to immediate the first incoming the cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): Due to (or as a consequence of)

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 2 Fetal death 4☐Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? res 22 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 26. Place of Death (Check only one) 1 Yes 2 No

25. Was case referred to medical Yos 2 No

Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27 Manner of Death 1X Natural 2 Accident

5 Pending investigation 6 Could not be determined 3 Suicide 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29c. License number

2 Medical Examiner: On the bases of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapper stated. 29d. Date signed (Month, Day, Year) March 20 2004

29b. Signature and title of certifier

OCME M

111 Penn Street, Baltimore, Maryland 21201

State Registrar

4 RIPPLE 31. Date filed (Month, Day, Year)

30. Name and a res of peren who

32. Registrar's Signature

9 2004

ed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

ORIGINAL

	,	,		State of M				nd Mental Hy	_	ibie.		
			For State Registrar			Certificate				004	09	581
	Physici	an	Decedent's Name (First, Middle,					2. Date of De Month	Day	Year	3. Time of	
	/Medic	al	Walt 4a. Facility Name (If not institution,	er Frederic			own, or Location o	March f Death	19 4c. Count	2004 ty of Death	1922	PM
	Examin	er	SunBridge Care			Elkto				cil		
	Funeral Director			3. Sex 7. As	ge (In yrs. last 92	birthday) If Under 1 Yrs. Months [Year If Under 2 Days Hours	Min. 8. Date of Bin (Month, Date August	th ly, Year) 11, 1911	Countr	ce (State o. Y) Land	r Foreign
	D		Usual Residence of Decedent 10a. State 10b. County			own or Location					d. Inside Cit	tv Limits
	Maryla f shor	ξ	Maryland Cecil			sapeake Ci	tv				1 Tes	
	or 28a	Director	10e. Street and Number		, 0,10	10f. Zip C	ode		10g. Citizen of			
	s 23a		716 Mt. Nebo R	oad 12. Was Decedent	Ever in II S	219.		in? (Specify Yes or No		ed Sta		
36	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. I thauth and Mental Hyglene. Item 27 is marked other than "natural; or Items 23a or 28a-f show other traumatic event, If a Modical Examinational be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Forces	?	If Yes, specify		gin? (Specify Yes or No , Puerto Rican, etc.)	Spec.	ack, White, et	c.	
Baltimore, Maryland 21215-0036	72 hou	Completed	15. Decedent's (Specify only highest	Education grade completed)	11	6a. Decedent's Usual ((Give kind of work life. DO NOT use	Occupation done during most	of working	16b. Kind of 1 Hardwa		istry	
121	within ene.	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	Owner/Op			Applia		ore	
م 2	be filed ntal Hygi ed other event, t	Be C	17. Father's Name (First, Middle, L.	ast)	, I	· L		r's Name (First, Middle				****
ylar	should be and Mental s marked o umatic eve	To	Charles W. Coo					y E. Arran		0.1.7.4		
Mar	d 2 sh th and th sin traum		19a. Informant's Name/Relationshi					r or Rural Route Numb nerville,			iode)	
ē,	s 1 an of Heal item 2 other		Walter E. Cool 20a. Method of Disposition		20b. Place	of Disposition (Name	of	Date Oate	20c. Location	- City or Tow		
Ë	nit. Pages partment of ortant: If i injury or		1 ☐ Burial 2 🛣 Cremation : 1 ☐ Donation 5 ☐ Other (Specific Control of Cont	ecify)	R.A. Inc.	eter, crematory or other Ferris &	Co.	004_	West Perns	Cheste ylvani	r, a	
Balt	permit. Pages 1 and 2 Department of Health a Importent: If item 27 it any injury or other tra ance.		21. Sign vure of Funeral Service Li	8 Auce	2	Hicks H	Address of Facility OME for Stockton	runerals, Street, E	P.A. lkton,	Maryla	nd 21	921
760.74	eath certificate be elecuted with attending physician and minimal in a pipe. for use as the burial-transit	Ilcal Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumor Due to (or as Due to (or as	nia s a consequent	ce of):					nterval Bety Driset and D days	Death
P.O. Box 68	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	ath 3 ⊟Ectopic preg				ate of deliver lonth E		(ear
	w requires that been signed b should be deta	ed by Pl	Part II. Other significant condition Acute Renal F		but not resultin	g in the underlying cau	ise given in Part I.		tobacco use cor Yes 2 No	ntribute to the		
Reco	The law re ate has bee page 2 sho	omplet	<u>Coronary Arte</u> Dysphagia	ry Disease				24a. Was auto perfi 1 \(\triangle Yes		Were autop: prior to com death? 1 \(\text{Yes} \) 2	sy findings a pletion of ca \to No	available ause of
/ita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	of Death (Check only				
Division of Vital Records,	ing Phys After this uneral dii	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inj (Month, D	ury 28	Outpatient 3 DOA b. Time of 28c Injury	2. Injury at Work?		idence 6 🗆 Ot how injury occu			
Divisi	al or Attend a after death I Director: A d in by the f	Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of Ir	njury - At home atc. (Specify)	, farm, street, factory, o	office	28f. Location (City or To	Street and Nurr wn, State)	ber or Rural	Route Numi	ber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	t of my knowle of examination stated.	dge, death occurred at and/or investigation, in	the time, date and n my opinion, deat	d place, and due to the th occurred at the time,	cause(s) and n date and place	nanner as sta , and due to t	ted. he cause(s))
}	To ti withi To ti comp	W	29b. Signature and title of certifier	Nelow	MO	29c.	License number	223	29d. Date sign		ay, Year)	04
	7		30. Name and address of person welchor E. Mac				Street,					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regist 2014	trar's Signature	w D. A	DE T					

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment o				iene •g. No. 20 () 4	09582
	Discontact and		1. Decedent's Name (First, Middle, Last)	. 1					2. Date of Deal		əar	3. Time of Death
	Physici /Medio		1011	av 19501	1	,			March	3, 2004		6:00 a M
	Examin		4a. Fecility Name (If not institution, give s.				n, or Location	of Death		4c. County of		
			1836 Metzerott Roa		(In one local birds do)	Ad 6	elphi ear If Under	24 Hrs	8. Date of Birth	Prince		
H	Funeral		5. Social Security Number 6. Sex 1 1	M 2XF	(In yrs. last birthday) 81 Yrs.	Months Da		Min.	(Month, Day,	Year)	Count	ece (State or Foreign y) ginia
4	Director		Usual Residence of Decedent					l	1146. 10	, 1722	VIL	511114
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation					10	d. Inside City Limits
	a-f s	ctor	Maryland Prince G	eorge's	Ade1ph	ni						1 ☑ Yes 2 ☐ No
	or 28)ire	10e. Street and Number			10f. Zip Coo	de		1	0g. Citizen of Wha	t Count	ry?
	ath w	ral	1836 Metzerott Roa				0783			U.S.A.		
	er de	by Funeral Directo	T, Manual Gratas	12. Was Decedent Ev Armed Forces?		Was Decedent If Yes, specify (of Hispanic Or Cuban, Mexicai	igin? (Spec n, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Black, 1	Amenca White, et	
36	rs aft	oy F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates:	,	1☐Yes 2∏	No Specify:	:		Specify:	Whit	- 0
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-1 show ta Medical Exerciter mast be notified at	ed	15. Decedent's Educ	cation		dent's Usual Oc				16b. Kind of Busin		
215	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	life.	kind of work do DO NOT use re	one during mos stired)	st of workin	g	Langley		
21	giene giene artha	Completed	12			lanager				Shopping	Cen	ter
nd	al Hy d oth	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)		
yla	Ment Ment arke	ပ္	Robert E. Smith		-					een Kid		
Maryland	2 sh and is m		19a. Informant's Name/Relationship (Type John Davidson - St			-				, City or Town, Sta lphi, MD		
e,	1 and 1ealth om 27 ther t		20a. Method of Disposition	pouse	20b. Place of Dispo				Company of the last of the last	20c. Location - Cit		n State
ğ	in of h		1 ☐ Burial 2 ☑Cremation 3 ☐ Re	emoval from State	cemetery, crea	matory or other	place)					
Baltimore,	it. Pa intmer intant njury		'4 □Donation 5 □ Other (Specify) 21. Signature 1 Funeral Service License		Metropolit	an Crema 2. Name and Ac			/2004			Virginia
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked othar than "netural; or Items 23e or 28a-f show amportant: or other traumatic event, Ital Medical Eracidizations at the coffice of one.		21. Signature in Full and Service Encloses	H/ang				out		uneral Ho sville, N	-	20781
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Gause (Final	eations that caused the cause on each line	he death. Do not en	_	1 0			est,	1	Approximate nterval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Aug to (or as a	consequence of):	an	n bol	esy	γ)			
	Examiner			Seucs	e Pho	ma.	Hd 1	Apt	cu to	,		
		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause Disease of kney	Due to (or as a	consequence of):			110	1.5			
	cuted nd ransit	Examiner	that initiated events c.	Hopp	ere ter	Sim						
0,	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	EX	resulting in death) Last		consequence of):	- 10	1	1				
8760,	ate be hysic	ical	d.		man o	are the	0	Vole	ase		-	
9	entifica ling ph e as ti	Physiclan/Med	IF FEMALE:									
Вох	leath certifi attending I for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregna				23d. Date of Month		/ Day Year
	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at ti 9 Unknown	me or death 5L	Other (specify	//					
P.0	res that the de igned by the a be detached f		Part II. Other significant conditions conf	tributing to death but	not resulting in the u	nderlying cause	given in Part I	l.	23e. Did tob	pacco use contribu	te to the	cause of death?
Records,	uires sign id be	d by							1 🗆 Ye	s 2010 3	Probal	bly 4 □Unknown
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Re	he lav e has age 2	E							autops	y prior ned? deat	r to comp th?	pletion of cause of
Vital		0	25. Was case referred to medical				26. Place	e of Death	1 ☐ Yes 2	- 72 (10	105 2	I No
<u> </u>	Physician: r this certificated director,	To B	examiner? 1 Yes 2 No	ospital: 1 Inpatient	2 ER/Outpatier	nt 3 DOA	Other: 4 Nu	ursing Hom	ne 5 X Heside	ence 6 Other (Specify)	
Division of	를 를 돌		27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. l	Injury at Work?	2	8d. Describe ho	w injury occurred		
ioi	Attending ir death. actor: After by the fune	atlc	1 Natural 5 Pending 2 Accident Investigation				1 ☐ Yes 2 ☐	No				
Σį	l or Attendater deatl Diractor:	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, sti (Specify)	reet, factory, offi	ice	2	8f. Location (St. City or Town	reet and Number o n, State)	r Rural I	Route Number,
Ω	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier DE Certifying Phys	ician: To the best of	my knowledge deat	h occurred at th	e time date ar	nd place, as	nd due to the co	ause/s) and manns	ar ac etal	red.
	To the Hospital or Attent within 24 hours after death To the Funeral Diractor: completely filled in by the	Medical	(Check only 2 Medical Examin		xamination and/or in	vestigation, in m	ny opinion, dea		d at the time, da	ate and place, and	due to ti	he cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	700		Zac. Lic	ense number			9d. Date signed (N		
Λ			steller !	K		ע	4099	8	, n	aurun :	1 6	70.1
1			30. Name and address of person who cor	mpleted cause of dea	ath (Item 23a) (Type,	Print)	N ST	- H.	rait.	Me N	10	2787
			31. Date filed (Month, Day, Year)	\$2. Registrar	's Signature	1 4 7 7 7 1 1 1 0	7 31	, , , ,	MALTO	1 IIX IV	10.	2702
	Sta Registi		MAR 0 8 2004	Bloke	1 hos	Be						

		1 - State Registrar 1. Decedent's Nam	a (First Middle			Ce	rtificate c	of Death		Reg.	ne 20 (. 320
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CXAIIIII	lei		Nursing					umbia			Howard	out.
Funeral		5. Social Security N		. Sex	7. Age (in yrs	. last birthday)	If Under 1 Ye	ear If Under 2	24 Hrs. 8. Da	te of Birth	9 1	Birthplace (State or For
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V 2565		Usual Residence of 10a. State	of Decedent 10b, County		10a C	ity, Town or Lo						
sho a	5	MD					Cation					10d. Inside City Li 1⊕ Yes 2□
n or 28e-f show be notified at	Director	10e. Street and Nu	Anne Ar	under		Laurel	101 7: 0-1					Λ
E G	ā		h Bruce	Charat			10f. Zip Cod			10g.	Citizen of What	Country?
ms 23a	Funeral	11. Marital Status	n bruce	12. Was Dece	dent Ever in U	J.S. 13. \	207		in? (Specify Y	as or No-	U.S.A.	merican Indian.
al', or items 23a Examiner must	Fur		ried 2 Married	Armed For	ces?		**	of Hispanic Orig Cuban, Mexican,	Puerto Rican,	etc.)	Black, W	
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i of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi		Charli D						ice Stre				
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Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, II <u>once.</u>	1	21. Signature of Fu			11/1							Maryland
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			10 0100000, 01 00	pholications that ca	used the dear	th. Do not ente	er the mode of o	reet, N	ardiac or respi	ratory arrest.	OH, D.C	Approximate
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Physi	cian	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
/Med		Joan Y	onne	Dunn				March	7, 2004	+	8:00 P M
Exam	iner	4a. Facility Name (If not institution, give		(ber)		4b. City, Town, or	Location of De	eath	4c. County	of Death	
		914 Lamberton					er Spri			ntgome	
Funera		5. Social Security Number 6. Se	х]м 2 ⊠ F	7. Age (In yrs. last t		If Under 1 Year Months Days	If Under 24 H	lin. (Month, Day	, Year)	9. Birthple Count	ece (State or Foreign
Directo	r	3/8-42-/663		7.5	Yrs.			Dec. 9,	1928		h Carolin
and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation				10	Od. Inside City Limits
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the N	Director	Maryland Montgome	ery	Silv	er S	pring					
with B or	급					10f. Zip Code			Og. Citizen of V	What Count	ry?
eath	era	914 Lamberton Dr		dent Francis III S	1 42 14	209		(2)	US		
ltem Item	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed Ford		13. V	vas Decedent of H Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		e - America ck, White, e	
rs aff	S F	3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 If Yes, Give Year or Da	9	1	☐Yes 21 No	Specify:		Specify	White	2
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Hyg Hyg Sther	Ö	17. Father's Name (First, Middle, Last)		+		memaker	18. Mother's N	lame (First, Middle, I	Own I		
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ihoul mari	2	19a, Informant's Name/Relationship (Ty	-	1 1 10	h Mailio	Address (Street		Rural Route Number	City of Taylor	Charles 7:- /	2-4-1
d2: th ar t7 is trau				usband	914						
Hea Hea		James Thomas Dunr 20a. Method of Disposition	, SI.	20b, Place	フ リ ュ of Dispos	Lamberto	n Drive	Silver S	Spring. 20c. Location -		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23s or 28s-f show any injury or other traumatic avant. Its Medical Evaluins in the rottled at		1 ☐ Burial 2 ☑ Cremation 3 ☐ F	emoval from S	comet	ery, crem	atory or other place	' Ma	rch 9,	200. Location -	City of Tow	m, State
rtme rtant		* 4 □Donation 5 □ Other (Specify)	1	THE CT O	· Cr	ematory		2004 A	1exand	ria, V	Virginia
Depa mpo mpo iny ir		21. Signature of Funeral Service Licens	1/21	KAN	Fr	Name and Addres ancis J.	s of Facility Collin	s Funeral	Home In	10	
40200		1/1/1/ Marion	4		50	U Univer	sity Bl	vd. W., Si	lver Sr	oring,	MD 2090
	7	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	cations that car re cause on ear	used the death. Do ch line.	not ente	r the mode of dying	, such as card	iac or respiratory arre	est,	1	Approximate nterval Between
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icate be executed physician and the burial-transit	dical									1	
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death certifi e attending od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		ome of pregnancy th 2 Petal deat	h 3 □E	Ectopic pregnancy				of delivery	
0 0 0	sici	1 ☐ Yes 2 ☐ No		nt at time of death		Other (specify)			Mon	ith D	ay Year
that the de ned by the a detached t	Phy	9 Unknown									
8 5 8	by	Part II. Other significant conditions cor	tributing to dea	th but not resulting	in the und	derlying cause give	n in Part I.	23e. Did tob	acco use contri	bute to the	cause of death?
w require been sig should b	ted							1 □ Ye	s 2 🛂 No	3 Probab	oly 4 □Unknown
> 40	Completed							24a. Was an	24b. W	/ere autops	y findings available
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ician: Th certificate rector, pag	a	25. Was case referred to medical					26 Place of D	1 ☐ Yes 2 eath (Check only one		☐ Yes 2	⊔ No
y S	OB	examiner? 1 ☐ Yes 2 🔀 No	ospital:	atient 2 ER/O	utnatient	3 DOA Othe		Home 5X Resider	_	r (Canaihi)	
g Ph er th eral	n: T	27. Manner of Death	28a. Date of	Injury 28b.	Time of	28c. Injury Work		28d. Describe how			
Hospital or Attending I 24 hours after death. Funeral Director; After tely filled in by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(MOINII,	Day Year)	Injury		? es 2 □ No				
if or Attendi after death. Director; A d in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of	f Injury - At home, f	arm, stree	et, factory, office		28f. Location (Str.	eet and Numbe	r or Rural F	Route Number.
pital or A ours after ieral Direc filled in by	ert	4 Homicide	building	, etc. (Specify)				City or Town,	State)		
A Hospital 24 hours 6 Funeral etely filled	aic	29a. Certifier 1⊠ Certifying Phys	ician: To the b	est of my knowledg	e, death	occurred at the time	a. date and place	ce, and due to the car	use/s) and man	ner as state	ed.
To the Hos within 24 h To the Fun completely	edical	(Check only Medical Examilione)	er: On the bas	is of examination at	nd/or inve	stigation, in my op	nion, death oc	curred at the time, da	te and place, ar	nd due to th	ie cause(s)
To the I	Me	29b. Signature and title of certifier				29c. License	number	29	d. Date signed	(Month, Da	v, Year)
TAL)	Rale	Ma	Men,	0.0		5 077				
	1	rand	11102			2003	5311		March	9, 20	04
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State of Maryland / Department of Health and Mental Hygiene 001 09585 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle | Last) 2. Date of Death 3. Time of Death Day **Physician** Month March 8 2004 11:35 A^M Dresser Roberta Stapp /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2128 Edgewater Parkway Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 T F Director 492-44-4810 63 29 Sep. 1940 Missouri Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examinar must be notified at Maryland 1 ☐ Yes 2X No Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2128 Edgewater Parkway 20903 U.S.A. Items 23a death v Funeral 12. Was Decedent Ever in U.S Amed Forces? 200 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Types 2 No 2004
If Yes, Give Year or Dates: 1975— Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 6 1 ☐ Yes 2 🖫 No Specify: þ Specify: White 3 ₩idowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than any niury or other traumatic event, the Means injury or other traumatic event, the Means of the M Elementary/Secondary (0-12) College (1-4or 5+) Captain Public Health Service 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Daniel Leazenby Mary Ann Bates 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sara Snyder - daughter 11222 Caisson Ct., Woodbridge, VA 22192 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Crematory 3-13-2004 Baltimore, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Euneral Service Licensee any ir ilan 11800 New Hampshire Av., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hepatic Failure 2 weeks /Medical Due to (or as a consequence of) **Examiner** Metastatic Breast Cancer 2 months Sequentially list conditions, if any, leading to immediate cause. It is a sequential to the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The faw requires thet the death certificate be executed physicien and s the burial-tran Due to (or as a consequence of): Physician/Medical the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months? Month 5 ☐ Other (specify) 4 Pregnant at time of death detached 9□ Unknown 9 Unknown ፩ signed t be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown nee. 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate 1 🗌 Yes 2**X** No Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a filled 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) npletely and manner stated. To the within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) else-MD 37903 March 10, 2004 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) Amy M. Keese, M.D. 6900 Georgia Ave. N.W., Washington, D.C. 20307

State Registrar 31. Date filed (Month, Day, Year)

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2004

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division of Vital

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8 Katina Dimitriou March 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Montgomery Shady Grove Adventist Hospital <u>Rockville</u> If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Funeral Days Months 1 □ M 21 F 78 Yrs Greece Director 228-82-4041 May 15, 1925 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene.

ant: if item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinar must be notified. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director VA Manassas 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9234 Byrd Drive U.S.A. 20110 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🔀 No Specify. Specify: Š Caucasian 3 Widowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Artist 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Georgia Tsilika Stavros Katsakos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11300 Ridgemist Terrace, Potomac, Maryland 20854 Mahy Polymeropoulos (daughter) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Depertment of Important: if it 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Injury Stonewall Memory Gardens 3/12/04 Manassas, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service-Price Funeral Home, Inc. 9609 Center St. Manassas, Virginia 20110 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a cor Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed physician end s the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 3 ☐ Saknown been signed by should be detect Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 ☐ Yes 2 ☐ No 1 Yes certificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: ို 2 No 2 DER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes this 28a. Date of Injury (Month, Day erai Director: After thi filled in by the funerel 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral C completely filled edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9900 Medical Center Drive - Rockville, MD 20850 William R. Dooley, M.D.31. Date filed (Month, Day, Year 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

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2004

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			For	State of Maryland /	Depa	artment of Health and rtificate of Death	Mental Hy	giene 200) 00 ====
			1 - State Registrar		Cei	rtificate of Death		Reg. No. 2 U	J4 0958 7
			1. Decedent's Name (First, Middle,	Last)			2. Date of De		3. Time of Death
	Physic /Medi		Ricardo	Martinez		Delgado	Month March		12:07 A. ^M
	Examir		4a. Fecility Name (If not institution,	give street and number)		4b. City, Town, or Location of De		4c. County of	
			Prince George's I	Hospital Center		Cheverly		Prince	e George's
-	Funeral			6. Sex 7. Age (In yrs. last b.	irthday)	If Under 1 Year If Under 24 H	s. 8. Date of Bir	rth S	
	Director		none	10XM 2□F 29	Yrs.	Months Days Hours Mi	Feb.	4, 1975	D. Birthplace (State or Foreign Country) Mexico
	D		Usual Residence of Decedent						HCKICO
	be tited within 72 hours after death with the Maryland ital Hygiene. It has not been a confined and other than "natural", or flems 23a or 28a-f show event, it a Ma-Jical Examinat must be notified at	Director	MD Prince	George's 10c. City. Tov	wn or Lo rerd	cation			10d. Inside City Limits Y☐ Yes 2 ☐ No
	ath with th	rai Dire	10e. Street and Number 6145 64th Ave	nue #1		10f. Zip Code 20737		10g. Citizen of Wh Mexic	•
	e	ne	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of Hispanic Origin? of Yes, specify Cuban, Mexican, Pue	Specify Yes or No	14. Race -	American Indian,
9	afte or h	by Funerai	1 Never Married 2 Marrie	Armed Forces? d 1 ☐ Yes 2 ☐ No If Yes, Give			exican		White, etc.
8	ours ral',	d b	3 Widowed 4 Divorced	Year or Dates:		AN 165 ZEINO Specily. [1	exican	Specify:	White
5	72 h natu	Completed	15. Decedent's (Specify only highest	Education 16a	a. Deced	lent's Usual Occupation	adina	16b. Kind of Busin	ness/Industry
7	within ene. then	npi	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done during most of w OO NOT use retired)	Sinning		
21	filed wi Hygien ther th	Son	6		un	employed		none	
Maryland 21215-0036	should be filed and Mental Hygis marked other matic event, III	To Be	17. Father's Name (First, Middle, La Jorge Felipe					Maiden Sumame) Delgado	Estrella
, Mar	1 ag		19a. Informant's Name/Relationship Francisco R.G	alvan/Friend 5	b. Mailin	g Address (Street and Number or F Glen Avenue	iural Route Numbe Lanham,	er, City or Town, Sta Maryland	ate, Zip Code) d 20706
ore.	of He		20a. Method of Disposition			sition (Name of	Date	20c. Location - Cit	
Ĕ	Of it is		1 ☑ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe	Hemoval from State MUITC	тра	Teeee ee autla 3/1	6/04	Hidalg	o,Mexico
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other 1 gnce.		21. Signature of Juneral Service		PĦ	TETP Agreent NALD 41 Columbia B	I FUNER	AL SERV	ICE,P.A.
П			23a. Part 1. Enter the disease, or co	omplications that caused the death. Do	not ente	or the mode of dying, such as cardia	ic or respiratory ar	rest.	Approximate
4	Physician		Immediate Cause (Final	ity one cause on each line.	_ 0	AL I	1		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Cesy o	7	Mooning	1-10)	wies	
Н	Examiner			Due to (or as a consequenca	of):		•		
10		-	Sequentially list conditions,	b. — Due to (or as a consequence	n6).				
	ed sit	i	Sequentially list conditions, if any, leading to immediate cause. Enter Underkying Cause (Disease or injury that initiated events	Due to to as a consequence	01).				
_	ate be executed sysicien and he burial-transit	Examiner	that initiated events resulting in death) Last	c	of):				
760,	be e) cien curia	calE		Due to (or as a consequence	OI).				
87	ate l			d					
68	ing p e as	Med	IF FEMALE:						
Вох	leath certificate attending phy I for use as the	an/	23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	1 3□	Ectopic pregnancy		23d. Date of	,
	ed fo	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death		Other (specify)		Month	Day Year
P.O.	at the by the	h	9 Unknown						
Records, I	The law requires that the death certifical ate has been signed by the attending phy age 2 should be detached for use as the	d by Physician/M	Part II. Other significent conditions	s contributing to death but not resulting in	in the un	derlying cause given in Part I.	23e. Did to	1.	e to the cause of death? Probably 4 Unknown
Ö	w requir been si should	Completed						3 2 2 110 02	Trobably 4 Conkriowii
ě	e law	n d					24a. Was a		autopsy findings available to completion of cause of
		ဂ္ဂ					perfor	med? deat 2 No 102	yes 2□ No
Vital	ysician: Th	Be	25. Was case referred to medical examiner?			28. Place of De	ath (Check only or		
	nysic dire	္	tX Yes 2 □ No	Hospital: 1 Inpatient	utpatient	3 DOA Other: 4 Nursing !	lome 5 ☐ Resid	ence 6 Other (Specify)
0	ding Ph h. After thi funeral		27. Manner of Death		Time of	28c. Injury at Work?		ow injury occurred	
Division of	tendir death. tor: Af the fur	Certification:	1 ☐ Natural 5 ☐ Pending Accident Investigat		350	M 1 Yes 2 No	Driver	NI Com	be accordent
S	or Attend after death Diractor: / in by the f	ific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 289.4 lace of injury - At nome, fa	ım, stre	et, factory, office	28f. Location (S	treet and Number of	Rural Route Number.
ā	af or A after 1 Dirac d in b)	ert	4 Homicide	building, etc. (Specify)	577	Jegin Jegin	630 Tow	State)	00 2077
	spitu nours nera		29a. Certifier 1 Certifying	Physician: To the best of my knowledge	e. death	occurred at the time, date and place	and due to the c	Sales (s) sales	as stated
	e Hc 24 } e Fu etely	Medical	(Check only one) XMedical Ex	aminer: On the basis of examination and manner stated.	d/or inve	estigation, in my opinion, death occi	irred at the time, o	late and place, and	due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier	1) -		29c. License number		29d. Date signed (M	onth. Day. Year)
	⊢ s ⊢ ŏ		V/V	Kallel		O.C.M.E.		March 7,	
	,	-	20 11	Terror)			1		
			30. Name and address of person wh	o completed cause of death (Item 23a) ((⊺ype, P	111 Penn Street	, Baltin	ore, Mary	land 21201
7	Stat	е.	31. Date filed (Month, Day, Year)	32. Registrar's Signature					
	Registra	~	MARII	2004 Danson	9	Acres V. 1			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 2, 2004 Day **Physician** Michael Horatio DaCosta 12:35 A.M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Clinton Prince Georges Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 ☐ F 58 Yrs. July 10,1945 Washington, D.C. 578-56-0761 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or 28a-f show 1≹Yes 2 □ No Directo Maryland Prince Georges Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 4911 Glassmanor Drive; Apt. 102 20745 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Armed Folces: 1 ZAYes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: Black If Yes, Give Year or Dates: 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Washington, D.C. Elementary/Secondary (0-12) College (1-4or 5+) Metropolitan Police Dept. Police Detective 2 years 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Heatth and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event Be Reginald DaCosta Sarah Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Michelle DaCosta (Daughter) 10516 Beacon Ridge Drive; Bowie, Maryland 20721 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) March 9,2004 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery Adelphi, Maryland 22. Name and Address of Facility
R. N. Horton Company Morticians, Inc.
600 Kennedy Street, N.W.; Washington, D.C. 21. Signature of Funeral Service Licensee anne 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myo coin chal **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records. End Stage Rural Disease 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Drubeter mellity 24a. Was an autopsy 1 Yes 2 No Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Proutpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of config 29d. Date signed (Month, Day, Year) 29c. License number D 0055120 m) Karre March 3 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard Palma 1328 Southern Areme SE Suck 310 Washington DC 31 Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 855 Month 3 **Physician** EDWARDS 6 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapelus
If Under 1 Year V If Under 24 Hrs. Arundo Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. NV 1 M 2 F 059-14-2072 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County or items 23a or 28a-f show of Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-1 show, other traumatic avent, the Medical Executary instituted at 1 Yes 2 □ No Director MD Anne Arundel Edgewater 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 3528 South River Terrace 21037 TISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Xes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. init. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene. ortant: if Item 27 is marked other then "natural", or Itel injury og other traumatic event, the Medical Exercitinal injury og 1 ₩ Never Married 2 Married 1 ☐ Yes 2X No Maryland 21215-0036 Specify. Specify: White à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner Boat Marina 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeannette Levy Harry Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21037 3526 South River Terrace, Edgewater, MD Jill Bourne, Cousin Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State permit. Page Department of Important: If any injury og Metropolitan Crematory 3/7/04 Alexandria, VA 21. Sign vure Funeral Service 22. Name and Address of Facility icunsee 42 Hudson Street, Annapolis, MD 21401 Part1. Enjoi the diseas shock of heart takere. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1, Ent Immediate Cause (Final disease or condition resulting in death) **Physician** 20ti ON We /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. physicien the IF FEMALE: use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be def Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 No 1 Yes certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 3 No 1 SInpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No м death. investigation 2 Accident within 24 hours after death To the Funeral Director:, completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only onel and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 400 5 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annapolis, Maryland 21401 Nancy F. Snow MD 2001 Medical Pkwy

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Oay, Year)

MAR 0 9 2004

32, Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

September Sept				1 - For State Registrar	State of Maryla	nd / Depa		Health and	l Mental Hyg	og. No. ZUU	+ 0959
Holy Cross Hospital Size Continue Co				Margaret A. E	ason				Month		3. Time of Death 2:44pm ^M
Little Teachers of December Total State December Total State		Funeral	er	Holy Cross Ho 5. Social Security Number 6. S	spital ox 7. Age (In yrs	• •	Silv If Under 1 Ye	er Spri	rs. 8. Date of Birth (Month, Day,	Montgo	omery thplace (State or Foreign ountry)
College (1 stor 5) College (1 stor 5) College (1 stor 5) Teacher T		D	or	Usuel Residence of Decedent 10a. State 10b. County	10c. 0	city, Town or Lo		on	12/07/	/24 Nor	10d. Inside City Limits
Physician Medical Examiner Provided Texaminer 21215-0036	within 72 hours after death with the Niene. iene. Than "natural", or Items 23a or 28e-1 Tra Medicel Examinar must be modif	by	10e. Street and Number 7200 Jaywick A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	VC 12. Was Decedent Ever in the Armed Forces? 1 Yes 2 (Armed) Yes Give Year or Dates: ducation de completed College (1-4or 5+)	U.S. 13.	10f. Zip Code 2074 Was Decedent of Yes, specify Ci	f Hispanic Origin? uban, Mexican, Pue lo Specify: cupation le during most of w	(Specify Yes or No- erto Rican, etc.)	USA 14. Race - Ame Black, Whit Specify: B	puntry? srican Indian, e.e. etc. lack /Industry	
Physician Medical Examiner Provided Texaminer yland;	ould be filed Mental Hyg tarked othe	Be	unknown						•		
Physician Medical Examiner Provided Texaminer 3altimore, Mar	ermit. Pages 1 end 2 sh lepariment of Health and inportant: If Item 27 is m ny injury or other treum nce.		Bertha King -s 20a. Method of Disposition 1 □ Burial 2 ②Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Sister Removal from State R:	1605 Place of Dispo cemetery, crer iverda	Berry sition (Name of natory or other p le Par	Hill S (ace) 3/ Iress of Facility	t. Harri Date 2 13/04	sburg,Pa Riverdal	17704 Town, Slate e, Md	
25. Was case referred to medical examiner? 1	8760,	/Medical Examiner	cai	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events	a. Bacteremi Due to (or as a conse b. Sepsis Due to for as a conse c. Con est:	La quence of): LVE He	er the mode of d	ying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
25. Was case referred to medical examiner? 1	Вох	the death certifi / the attending ched for use as	ysician/Me	23b. Wes decedent pregnant in the past 12 months? 1 Yes 2 ******	1 Live birth 2 Fet:	al death 3					
25. Was case referred to medical examiner? 1		requires that I een signed by tould be deta	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the ur	nderlying cause o	given in Part I.			
27. Manner of Death 1		in: The law incate has b		25. Was case referred to modical					autopsy perform 1 Yes 2	ed? prior to death? ⊠ No 1 ☐ Yes	completion of cause of
29a. Certifier (Check only one) 29b. Signature and dittle of certifier 29b. Signature and dittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Kanwaljit Nasi, M.D. 1500 Forest Glen Rd Silver Spring, Md 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature	sion of Vi	ding Ph h. After th funeral	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Inj	ther: 4 Nursing ury at ork?	Home 5 Resider	nce 6 Other (Spec	ify)
30. Name and address of person the completed cause of death (Item 23a) (Type, Print) Kanwaljit Nasi, M.D. 1500Forest Glen Rd Silver Spring, Md 20910 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Divi	irec irec		4 Homicide determined 29a. Centifier 1 Certifying Physics	building, etc. (Speci	fy) owledge, death	occurred at the	time date and place	City or Town,	State)	etated
Kanwaljit Nasi, M.D. 1500Forest Glen Rd Silver Spring, Md 20910 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			Medic	29b. Signature and title of certifier	and manner stated.	ation and/or inv	29c. Licer	opinion, death acc	urred at the time, da	e and place, and due	to the cause(s)
Registrar MAR U 9 2004 Square / Sports				Kanwaljit Na 31. Date filed (Month, Day, Year)	si, M.D. 150	0Fores	st Glen		ver Spri	ng,Md 20	910

	113		1 = State MEND Item#18, per Registrer 1. Decedent's Name (First, Middle, Last)		d / Depa .cc <i>Cei</i>	artment of H rtificate of	lealth an Death	2. Date of De	Reg. No	200	4 09592
	Physici /Medi Examir	cal	Dennis Keit 4a. Facility Name (II not institution, give s 63 Meadow I			4b. City, Town, o		Month 0 3			
- 144 - 144	Funeral Director		5. Social Security Number 6. Sex 502-46-5911	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 I Hours N	Hrs. 8. Date of Bir (Month, Da 1 1 / 2 9	th y, Year)	9. Bir Co	thplace (State or Foreign buntry) rth Dakota
propagation of	28a-f show	ector	MD 10b. County Allegar	burg			100		10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
4	3a or	ä	63 Meadow Road	ā.		10f. Zip Code 2153	2		US	zen of What Co	ountry ?
17213-UU30	Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examina in use by intilied at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 □★es 2 □ No If Yes, Give Year or Dates:			? (Specify Yes or No uerto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White		
4 within 72 hours of	ne. nan "natur r Wedical	To Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. I	dent's Usual Occup kind of work done DO NOT use retired	during most of d)	working		nd of Business	
Maryland 21	ental Hygier ked other th ic event, th		12 17. Father's Name (First, Middle, Last) Melvin O. E	2 Erickson	18. Mother's Name (First,				Maidan	ufacti Sumame) Gurty Sr	
, Mary	other traumat	-	19a. Informant's Name/Relationship (Type Dianne Eric	oe, Print) Ckson - Wife			and Number or	rostburg	er, City o	r Town, State, 2	Zip Code)
Baitimore,	Pages 1 ment of He ant: If Iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	amount from State	emetery, cren	sition (Name of matory or other place n Cremat		Date /18/04		cation - City or ontowr	
Dall	Depart Import any in		21 Signature of Funeral Service License	al Ser le, MD	vice 21502						
	hysician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Mesoth	elio		g, such as care	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	xaminer	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of the consequence of t							
ate be executed	ohysician and the burial-transit	Ical Examiner	cause. Enter Undertying Cause (Disease or nitury that initiated events resulting in death) Last		-						
ecorus, F.O. BOX 66/60,	ied by the attending phy detached for use as th	Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			2	23d. Date of delivery Month Day Year				
ouires that	been signed by should be deta	þ	Part II. Other significant conditions con	tributing to death but not resu	liting in the ur	nderlying cause give	en in Part I.	23e. Did to			the cause of death?
ے ع	ate h page	Completed						24a. Was autop perfor 1 Yes	sy	prior to death?	topsy findings available completion of cause of
VILC	certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		3 DOA Othe		Death (Check only o			
Attending Physician:	After th funeral	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		ER/Outpation 28b. Time of Injury	28c. Injury Worl	4 Li idulalii	g Home 5 Resid 28d. Describe h			cify)
Duilding, etc. (Specify)								28f. Location (S City or Tow			iral Route Number,
L To the Hospital	within 24 hours after To the Funaral Directory completely filled in	Medical ((Check only 2 Medical Examin one)	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/on inv	estigation, in my of	oinion, death o	ace, and due to the occurred at the time, o	cause(s) date and	and manner as place, and due	stated. to the cause(s)
ToT	To T com	Σ	29b. Signature and title of certifier • George Henna	wi, MB	H	29c. License				signed (Month	
10	71		30. Name and address of person who cor	1, MD, 92	23a) (Type, I	Print) shop w.	ilsh K	Load Cu.	mke	e Inn d,	MO Z (502
	Sta Registr		31. Date tiled (Month, Day, Year) WAR 2 9 2004	32. Registrar's Signati	ure o	,					

			1 – For Registrar	State of Maryland / Dep	artment of Health and rtificate of Death		iene 2004	09593					
			Decedent's Name (First, Middle, Las		- Dodin	2. Date of Deat	h	3. Time of Death					
	Physic /Medi			Rose Elva Flat	her	Month March	Dey Year 9. 2004	12:10P M					
	Exami		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Dea		4c. County of Deeth	112 • 1 U.					
			Lorian Nursin	g Home	Mt. Airy		Carrol1						
la la	Funeral Director		376-30-7964	7. Age (In yrs. last birthday, ☐ M 2☑ F 97 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	8. Date of Birth (Month, Day, Feb.	9. Birth Cou 3,1907Wasl	place (State or Foreign ntry) n . DC					
	and		Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits					
	Maryl f sho	ō		Georges Lan				1 TYPS 2 No					
	28a	reci	10e. Street and Number		10f. Zip Code	10	Og. Citizen of What Cou	ntn/?					
	3a or	0	7402 Good Luc	k Road	2070		USA	,					
	deatl	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Ameri						
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Evanther must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 👿 No	1 ☐ Yes 2 ☒ No Specify:	no rican, etc.)	Specify: White,						
2-0	72 ho	Completed	15. Decedent's Edi (Specify only highest grad		dent's Usual Occupation	1	16b. Kind of Business/In	dustry					
21	ithin 180	nple.	Elementary/Secondary (0-12)	College (1-4or 5+)	kind of work done during most of wo DO NOT use retired)	rking							
2	led w lygier her th		12	пот	nemaker		Own home						
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me	To Be	17. Father's Name (First, Middle, Last)	Carl Winfield	Unknow	me <i>(First, Middl</i> e, <i>M</i> n	faiden Sumame)						
lan	and I and I s ma		19a. Informant's Name/Relationship (T		ng Address (Street and Number or R								
	s 1 and 2 of Health Item 27 I other tra		Roger Flather,		36 Whisper Tra								
Baltimore,	8 = 5		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify,	demoval from State	osition (Name of matory or other place) 03-	12-04	rentwood,						
Balti	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licens	22	2. Name and Address of Facility		neral Hom						
	3 1 4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
	Physician /Medical		shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. ALZHEIM	ERS DEMAN			Approximate Interval Between Onset and Death					
10 PM	Examiner			Due to (or as a consequence of):				,					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):									
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.									
oʻ	e exe ian ar urial-t	EX	resulting in death) Last	Due to (or as a consequence of):									
68760,	ate br	dical	(d									
		/Mec	IF FEMALE:	22-16									
Вох	death certifi e attending I id for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy		23d. Date of delive Month	ory Day Year					
o.	0 0 0	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Uriknown	4☐ Pregnant at time of death 5☐ 9☐ Unknown	Other (specify)			,					
۵.	that ned by deta		Part II. Other significant conditions con	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?					
Vital Records,	The law requires that the tee bas been signed by the bage 2 should be detached.	ed by				1 ☐ Yes	2 No 3 Prob	ably 4 □Unknown					
000	law requir as been si 2 should	Completed				24a. Was an	24b. Were auto	psy findings available					
R	The late has page	ШО				autopsy performe	ed? prior to cor death?	npletion of cause of					
ital	ician: T certificat rector, pa	Bec	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	YNo 1 ☐ Yes	2 No					
of V	1 N	To E	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatien	0.1		ice 6 Other (Specify	·)					
0 0			27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how							
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, str	M 1 Yes 2 No								
Division	al or Attenos s after deat Il Director: ed in by the	Certification;	4 Homicide determined	et and Number or Rura State)	l Route Number,								
	To the Hospital or All within 24 hours after or to the Funeral Directompletely filled in by	edical (29a. Certifier 1 Certifying Phy. (Check only one)	ner: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place restigation, in my opinion, death occur	, and due to the cau irred at the time, dat	ise(s) and manner as st e and place, and due to	ated. the cause(s)					
	To the within 2 To the complete	Me	29b. Signature and title of certifier	111	29c. License number	290	d. Date signed (Month, L	Day, Year)					
}	->)	1///	1260		3-9-0						
)	(2)		30. Name and address of person who co	empleted cause of death (Item 23a) (Type,		T I							
_	9			er, MD., 4 Culwe		Airy, M	d. 21771						
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 2004	2. Registrar's Signature	K)								

			For State Registrer	State of Marylar		artment of Hertificate of L			giene 20. Reg. No.	04 09591
	Physici /Medie		Decedent's Name (First, Middle, Last) Moses	Carmichael	Frid	lie		2. Date of De Month March	ath	3. Time of Death 6:29 P M
)	Examir		4a. Facility Name (If not institution, give Southern Mary)	and Hospita		4b. City, Town, or Clin	ton			Georges
	Funeral Director		5. Social Security Number 578-70-4053 Usual Residence of Decedent	7. Age (In yrs. 52	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da 12-3	th y, Year) - 51	Birthplace (State or Foreign Country) D.C.
	death with the Maryland ma 23a or 28a-f show rmat be notified at	tor	10a. State D. C. N/A		ty, Town or Lo					10d. Inside City Limits XXYes 2 □ No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 2812 Q Street	, S.E. #2		10f. Zip Code 2002	0		10g. Citizen of Wha	•
920	after or fta	þ	11. Marital Status **Mever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		American Indian, White, etc. Black
21215-0036	within 72 hours ene. than "natural", he Medical Exe	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wor	king	16b. Kind of Busin	
Maryland 2	should be filed within and Mental Hygiene. s marked other than " umatic event, the Mes	To Be Co	17. Father's Name (First, Middle, Last) Moses Fridi	е			18. Mother's Nan	ne (First, Middle,	Maiden Sumame) itt	
	and 2 shoul alth and Me n 27 is mark or traumati		19a. Informant's Name/Relationship (Type Diane Sheffiel			g Address (Street a			er, City or Town, Sta	te, Zip Code)
Baltimore,	permit. Pages 1 and Department of Healt Important: # Itam 2 eny injuryer other 1 once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	emoval from State G16	cemetery, cren	sition (Name of natory or other place Cemete		Date / 04	20c. Location - City Wash., I	
Balt	permit. Departimont Import any inj		21. Signatur of Funeral Service Licenson 23. Part. Enter the disease, or compli	100		Name and Address The Hous 814- Ups	se of W	illiam reet	s N.W	
58760,	Physician by Medical Examiner transit the prival-Iransit	edical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	le cause on each line.	o premiuence of):		, such as Caroliac	or respiratory an	1931,	Approximate Interval Between Onset and Death
P.O. Box 68		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	ıldeath 3 ⊑	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
of Vital Records, P	The law requires that the death certif ite has been signed by the attending tage 2 should be detached for use an	Completed by Ph	Part II. Other significant conditions con Relaysing Fan west	11.	0	derlying cause giver	n in Part I.	23e. Did to	'es 2 No 3 □	e to the cause of death?] Probably 4 Unknown e autopsy findings available
tal Re	ilcian: The lav certificate has rector, page 2		25. Was case referred to medical	1/			00 Pt4 P		med? deat	to completion of cause of 1? Yes 22 No
Division of Vi	Phys this ral di	ation: To Be	examiner? 1	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	Other	4 Li raursing n	ome 5 Resid	lence 6 Other (Sow injury occurred	Specify)
Divis	To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify				City or Ton	m, State)	r Rural Route Number,
	the Hosp in 24 ho the Funa ipletely fi	Medical	one) 2 Medical Examir	ician: To the best of my kno ler: On the basis of examina and manner stated.	wiedge, death tion and/or inv	estigation, in my opi	nion, death occur	red at the time, o	date and place, and	due to the cause(s)
	2 Some	2	29b. Signature and title of confiner	~ MD		29c. License			29d. Date signed (M Mer l	onth, Day, Year) 0 2004
	2		30. Name and address of person who co Kichard Palmer 13	mpleted cause of death (Item 28 Southern A			310 W	, hay h.	DK 2003	
¢.	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 2 200	32. Registrar's Signa	ature &	Sporks				

		1 - State of Maryland / Dep	partment of Health and Nertificate of Death		ne 2001, 0950					
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last) MARY DORR 4a. Facility Name (If not institution, give street and number) LAUREL REGIONAL HOSPITAL	FISHER 4b. City, Town, or Location of Death LAUREL	MARCH 8	Day 2004 3. Time of Death 9:15A. M 4c. County of Deeth PRINCE GEORGE'S					
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 Tr 83 Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug 12, 192						
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Exerciting must be notified at	by Funeral Director	10a. State 10b. County 10c. City, Town or In Maryland Prince George's Beltsvil 10e. Street and Number 11910 Holly Tree Court			10d. Inside City Limits 1 □ Yes 2 No Citizen of What Country? Inited States					
0036 fours after dea aral', or Items	d by Funer	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc. Specify: White					
d 21215-0036 filed within 72 hours af Hygiene other than "netural", or ant, tre Medical Exerti	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home	edent's Usual Occupation a kind of work done during most of work DO NOT use retired) Emaker	ang 16b.	Kind of Business/Industry Own home					
Maryland of 2 should be file th and Mental Hy 27 is marked oth	To Be	17. Father's Name (First, Middle, Last) Charles O. Dorr 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	18. Mother's Nam Ada C. ling Address (Street and Number or Rur							
Pages 1 and 2 nent of Health a nert of Health a nert; if Item 27 is 1ry or other tran	Herbert H. Fisher -Husband 11910 Holly Tree Court Beltsville, Maryl 20a. Method of Disposition 1									
Baltimore, permit. Pages 1 a Department of Hee Important: if item any injury or othe		21. Signature of Funeral Service Licensee	onald V. Borgwardt	Funeral H						
S/00, ale be executed hysician and hysician and hysician-transit	Examiner	23a. Pert1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2a. Cardiac Arrythm: Due to (or as a consequence of): Acute Myocardia: Due to (or as a consequence of): Atherosclerotic Due to (or as a consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death						
hat the death certific dby the attending p	by Physician/Medical E	d	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobacco	23d. Date of delivery Month Day Year use contribute to the cause of death?					
The law require tale has been signated as the page 2 should be the control of the	Completed	Hypertension; Hyperlipidemia		24a. Was an autopsy performed?	2 kg No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?					
Attending Physician: r death. ector: After this certific by the funeral director.	Certification: To Be C	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No	me 5 Residence 28d. Describe how inju	6 □Other (Specify) uny occurred and Number or Rural Route Number.					
Hospita 4 hours Funeral	edical Ce	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deat 2 Medicel Examine: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the cause(sed at the time, date an	s) and manner as stated. d place, and due to the cause(s)					
To the To the complet	Ž	29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number D22910		March 8, 2004					
St Regist	ate rar :	Asif Qadri, M.D. 4700 Berwyn House Roman (Month, Day, Year) MAR 0 9 2004 Asif Qadri, M.D. 4700 Berwyn House Roman (Month, Day, Year) MAR 0 9 2004		Maryland 20	0740					

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State of Maryland / Department of Health ar	nd Mental Hygiene 2004	0959
Certificate of Death	Reg. No.	
antl	2 Date of Death	2 Time of Death

			For State Registrar	State of Maryland	Cer	tificate of Dea	th		eg. No.	-007	U J	090		
		Н	Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h Day	Year	3. Time o	Death		
	Physicia /Medic		Robert Earl Fetne	r				February		, 2004	9:13	A M		
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or Locati	ion of Death		4c. (County of Deat	h			
			Holy Cross Nursing			Silver Spr				Montgomery				
3	Funeral Director		5. Social Security Number 6. Sex 578-16-4512	7. Age (In yrs. last 81	Yrs.	If Under 1 Year If Un Months Days Hou	ırs Min	8. Date of Birth (Month, Day, March 2.	Year)	9. Birthplace (State or Foreign Country) 922 North Carolina				
	filed within 72 hours after death with the Maryland Hygiene. If the than "natural", or Items 23s or 28s-1 show ont, the Medical Examiner must be notified at	lor	10a. State 10b. County Maryland Montgomer	y Silve:					10d. Inside C	ity Limits				
	r 28a	Directo	10e. Street and Number	y DIIVE.	r obr	10f. Zip Code		1	0g. Citiz	en of What Co	untry?			
	3a o		2917 Shanandale Dr			20904			USA					
^	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12 1 □ Never Married 2 ☑ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No		Vas Decedent of Hispanic f Yes, specify Cuban, Mex	Origin? (Spe	cify Yes or No- Rican, etc.)	1	4. Race - Ame Black, White				
003	hours a tural', o al Exer	by	3 Widowed 4 Divorced 15. Decedent's Education	1 XYes 2 No If Yes, Give Year or Dates: WW-II		☐ Yes 2 💢 No Specient's Usual Occupation	cify:			Specity: White Kind of Business/Industry				
215-0036	ithin 72 Je. nan "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done during i DO NOT use retired)		ng		eral Ac	counti	ng		
N.	lled w tygies her ti nt, th	12th Transportation Rate Specialist Of 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)												
and	0 = 0 5	Be												
Maryland	should and Men a marke umatic	은												
<u>∞</u>	od 2 s Ith ar 27 is trau	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Dorothy Mae Fetner- Wife 2917 Shanandale Dr. Silver Spring, MD												
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked any injury or phier traumatic evenue.		20a. Method of Disposition 1	moval from State		sition (Name of natory or other place)				ation - City or		2000/		
	artme ortani injury		* 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses			leaven Cem. Name and Address of Fa		/2004 S				20904		
e E	permit. Departr Imports any inji	Į.	* Bencha E	Wihn	11	800 New Ham	pshire	Ave.Sil	ver			0904		
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the death. Concause on each line. Chronic Lym				respiratory arre	est,		Approximat Interval Bet Onset and 5 Year	ween		
	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):									
	Examiner	_	Sequentially list conditions, if any, leading to immediate	Non-Hodgkins		phoma					1 Year			
	pe #s	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ce of):									
_	ficate be executed physicien and is the burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):									
ĝ	be ex			240 10 (01 43 4 0013644611	36 017.									
68760	phys s the	edical	d.											
.O. Box 6	death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23	d. Date of delin	,	Year .		
1	es that the igned by be detacted		Part II. Other significant conditions conti	ributing to death but not resulting	g in the un	derlying cause given in Pa	art I.	23e. Did tob	acco us	contribute to	the cause of c	leath?		
S D	law requires that the as been signed by th 2 should be detache	d by						1 □ Ye	s 2 X	No 3∏Pro	bably 4 🗆	Jnknown		
7	99 90	24a. Was an autopsy prior to co												
ecc	lawr as be 2 sh	9								prior to c		ause of		
r	The ate h	Somp						perform	red?	prior to c death? 1 ☐ Yes	ompletion of c	ause of		
r	The ate h page	Be Completed	25. Was case referred to medical examiner?			26. P	lace of Death	perform	ned?	death?	ompletion of c	ause of		
Vital H	The ate h page		examiner? 1 ☐ Yes 2 ☐ No Ho		Outpatient	_ Other		perform 1 Yes 2	ned? X No	death? 1 Yes	ompletion of c	ause of		
ion of Vital Records,	ling Physician: The h.	To Be	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	I Impatient 2 EH/	Outpatient o. Time of Injury	_ Other	Nursing Hom	perform 1 Yes 2 (Check only one	No No nce 6	death? 1 Yes	ompletion of c	ause of		
Vital R	or Attending Physician: The iter death. Director: After this certificate h in by the funeral director, page	ertification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 28t	o. Time of Injury	28c. Injury at Work? M 1 Yes 2	Nursing Hom	perform 1 Yes 2 (Check only one 1 Reside	ned? No nce 6 w injury	death? 1 Yes Other (Specioccurred	ompletion of c			
of Vital H	ling Physician: The h.	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29. Certifier 1 Certifying Physical Phys	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home,	o. Time of Injury farm, stre	28c. Injury at Work? M 1 Yes 2 eet, factory, office	Nursing Hom 2	perform 1 Yes 2 (Check only one 5 Reside 8d. Describe ho 8f. Location (Str. City or Town	ned? No nce 6 w injury eet and State)	death? 1 Yes Other (Specioccurred	mpletion of c No Route Num	ber,		

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Armstrong, M.D. 14201 Laurel Park Dr. #102 Laurel, MD 20707

31 Date filed (Month, Day, Year)
MAR 0 8 2004

32 Registrar's Signature

D432337

29d. Date signed (Month, Day, Year) February 29, 2004

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Deeth Month 5 **Physician** 2004 5:00 AM OPHELIA /Medical 4c. County of Death 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner PINE VIEW FUTURE CARE CLINTON PRINCE GEORGE'S 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 91 Yrs. Funeral Birthplace (State or Foreign Country) Days Hours 1 □ M 2 ☑ F Director 579-20-0347 24 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mentel Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28a-1 show any injury or other traumatic event, the Medical Evantiner must be notified at ence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N Yes 2 No Funeral Director DC WASHINGTON 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20002 U.S.A. 2005 MARYLAND AVENUE N.E. APT 102 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 25 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 BLACK 1 ☐ Yes 2 No Specify: Completed by Specify 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WAITRESS 6th PRIVATE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) TARRY JAMES **ESTELLE** TAYLOR 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE B. HUNT/DAUGHTER 2005 Maryland Ave. N.E. # 102 Washington, DC 20002 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State

Physiciar /Medica

Examine

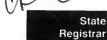
To the Hospital or Attending Physician: The law requiras that the death certificate be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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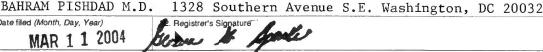
4 ☐ Donation 5 ☐ Other (Specify	Ha	rmony Cemet	ery	3/12/04	Landov	er,Maryland						
21. Signature of Funeral Service Licens	900	22. Name and	2. Name and Address of Fecility Johnson & Jenkins Funeral Home									
K. D. Harsh	all	716 Kei	nedy Street	t N. W. V	Vashingt	on DC 20011						
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea one cause on each line.	th. Do not enter the mode	of dying, such as cardia	ac or respiratory e	rrest,	Approximate Interval Between Onset and Death						
Immediate Cause (Final disease or condition resulting in death)	Congest	ive Heart F	ailure			1						
rosoning in county	Due to ((or as a consequence of): ension										
Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):										
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.												
Part II. Other significant conditions co	ntributing to death but not res	sulting in the underlying ca	use given in Pert I.	23b. Did	tobacco use co	ntribute to the cause of death?						
Anemia				10	Yes 2□ No	3 ☐ Probably 4 ☑ Unknown						
Rectal Bleedin	ng			24a. Was perfo	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?						
1				101	ies zinu	1 ☐ Yes 2 🛣 No						
25. Was case referred to medical examiner?	U 9-1			ath (Check only o	ne)							
1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ DO	Other: 4 A Nursing	Home 5 ☐ Resid	dence 6 □Oth	er (Specify)						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of 28 Injury M	c. Injury at Work? 1 Yes 2 No	28d. Describe h	now injury occur	red						
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At h. building, etc. (Specif	ome, farm, str <i>ee</i> t, factory, y)	office	28f. Location (S City or Tox		er or Rural Route Number,						
29a. Certifier 1⊠ Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred a tion and/or investigation,	t the time, date and place n my opinion, death occu	e, and due to the ourred at the time,	cause(s) and ma date and place,	nner as stated. and due to the cause(s)						
29b. Signature and title of certifier	D		License number		•	i (Month, Day, Year)						



31. Date filed (Month, Day, Year) MAR 1 1 2004

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

12 Burial 2 ☐ Cremation 3 ☐ Removal from State



State of Maryland / Department of Health and Mental Hygiene 2006 09598 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 29, 2004 Erthea Gaines 5:15pm^M /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges 6801 Bock Rd. #120 Fort Washington Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1□ M 2 F 578-64-1279 62 23, 1941 Wash, Oct. Director D.C Usual Residence of Decedent 10d, fnside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Maryland Prince George Fort Washington Direct 10g. Citizen of What Country? 10e. Street and Number tems 23a or 6801 Bock Rd. #120 20744 United States Funerai death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. within 72 hours after 1 ☐ Yes 21 No 1 Never Married 2 Marned 0 Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: **Black** 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced "natural" Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: If Item 27 ie marked other the enty injury or other traumatic event, ILAA 900. 10th Housekeeper Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Olis Sykes Elma Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Juanita Brown/Daughter 2144 Alice Avenue #3, Oxon Hill, MD. 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) March 8, 2004 Lincoln Memorial Suitland, MD. 21. Signature of Funeral Service Licenses Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. sva 20747 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between AtHero Sclentic Heart OiseAJR fmmediate Cause (Final disease or condition resulting in death) Physician /Medical Der **Examiner** sequentian, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ugscular niverse Examiner eve B The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 clonths?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) P.0. 9☐ Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed evalparesis 20 TO CU 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Dysauthui A 2º TO 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient Medicai Certification: To 1 Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) In by 4 - Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ona) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cartifier R345 106 Irond Strateris inmulator leted cause of death (Item 23a) (Type, Print) 30. Name and address of person w Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 1 2004 Registrar

			1 - For State Registrar	State of Maryland / Department	artment of Health and Martificate of Death	-	ne 200	4 1959
>	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Last) Charles 4a. Facility Name (If not institution, give some charlotte Hall)	treet and number)	Guthrie 4b. City, Town, or Location of Death Charlotte Hall	March	Day Year 11,2004 4c. County of Death St.Mary	3. Time of Death 10:15a M
	Funeral Director		5. Social Security Number 6. Sex			8. Date of Birth (Month, Dey, Yei 7/28/19	ar) 9. Birth	pplace (State or Foreign intry)
	ar death with the Marylan Items 23a or 28a-f show RELIMEL COLVENING AL	Director	10a. State 10b. County MOntgome 10e. Street and Number 9617 East Light		Spring 10f. Zip Code 20903	10g.	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No untry?
9003	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Ezairi agri, just be to diffied at	d by Funeral Director	11. Marital Status 1 Never Married 2 Narried 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1942 -	Was Decedent of Hispanic Origin? (Spot If Yes, specify Cuban, Mexican, Puerto		USA 14. Race - Ameri Black, White, Specify: White	ite
Maryland 21215-0036	filed Hygi ther snt, I	e Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 1	College (1-4or 5+) College (1-4or 5+) E]	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) ectrician 18. Mother's Name	ng 16b.	ndustry	
Marylan	2 should and Mer is marke sumatic	To Be	Nicholas Ward (pe, Print) 19b. Mailir	Berna	dine Mar	rch y or Town, State, Zij	
d)	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tra		Catherine S.Guth 20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature Funeral Service Licenses	emoval from State 20b. Place of Dispo cemetery, crer Chesap	matory or other place) Deake Crem. 3/13/	04 B	Location - City or To	own, State Le Md
	Physician /Medical		21. Signature of Funeral Service Life isset 23a. Part1. Enterline disease, or complies shock, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	er Sprin	Approximate Interval Between Onset and Death			
1760,	ate be executed hysician and he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
.O. Box 68	death certific e attending pi d for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive	ery Day Year
s, D	The law requires that the tee been signed by the bage 2 should be detached.	by	Decubuti	tributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacci	o use contribute to the	1/
Vital Record		e Completed	Drayetes Me hypertensize 25. Was case referred to medical	ellitus	26. Place of Death	24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of
of	ys dil	ition; To Be	examiner?/	ospital: 1 Inpatient 2 ER/Outpatient 2 ER/Outpatient 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	t 3 DOA Other: 4 rsing Hon	ne 5 Residence		ý)
Division	in the	i Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, strubuilding, etc. (Specify)		28f. Location (Street and City or Town, Sta	nte)	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	icien: To the best of my knowledge, death er: On the basis of examination and/or inv and manner stated.	occurred at the time, date and place, a vestigation, in my opinion, death occurred	ed at the time, date a	(s) and manner as signed place, and due to	o the cause(s)
)	4ct)	30. Name and address of person who con	npleted cause of death (Item 23a) (Type,	Print) 1005 209	Rd.	3/11/	3004
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signature	hoards	cvick).	0 000/	U

			For State Registrar	State	of Marylar		artment of rtificate of				ene g. No. 2004	09600
	Physici /Medio		1. Decedent's Name (First, Middle Sylvia O. Go.]							Date of Death Month arch 3	, Day 2004 ar	3. Time of Death 2:35 P M
	Examin		4a. Facility Name (If not institution Renaissance Gar		iderwood		4b. City, Town, Silver	Sprin	ng		4c. County of Death	ery
	Funeral Director		5. Social Security Number 068-03-9663 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	9 Yrs.	If Under 1 Yea Months Days		Min. No	Date of Birth (Month, Day, 1 DV. 4, 19	Year) 9. Birth Co. Miss	nplace (State or Foreign untry) SOUTI
	Maryland -f show	tor	10a. State 10b. County	pomery	10c. Ci	ty, Town or Lo	Spring					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	h with the 23a or 28a st be noti	Funeral Director	10e. Street and Number 3122 Gracefield	Road, #6	509		10f. Zip Code 2	0904		10	g. Citizen of What Co United St	•
920	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f ehow the Madical Exercitive ribel be indiffied at	þ	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 ☐ Yes	2 ∏X No Bive	l.S. 13.	Was Decedent of If Yes, specify Cu			Yes or No- an, etc.)	14. Race - Ame Black, White Specify: Wh	
Maryland 21215-0036	within 72 hours ene. then "neturel", he Medical Ex.	Completed	15. Deceder (Specify only higher Elementary/Secondary (0,12)	t's Education st grade completed College	(1-4or 5+)	(Give	dent's Usual Occi kind of work doni DO NOT use retir	ipation during mos ed)	st of working	1	family bu	
land 2	ould be filed with Mental Hygiene arked other the atic event, the	To Be Co	17. Father's Name (First, Middle, Herman	Last)	Taubman			18. Moth		irst, Middle, Mi	aiden Sumame)	Kitz
	d 2 sh th and 7 is m traum		19a. Informant's Name/Relation: Madeleine Gold	ship (Type, Print) le -daught	ter	19b. Mail:	ng Address (Stree Parkway	cheve	er or Rural Re Erly, N	oute Number, Marylan	City or Town, State, 2 d 20785	lip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1			cemetery, cre	osition (Name of matory or other pi itan Cre	matory	Date y 3/4/2		Oc. Location - City or lexandria,	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service	<. H	<u>~~</u>	- 4	400 Powa	er Mi	LL Rd.	Beltsv	Home, P.A	land 20705
, in	Physician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	BIBAS	ILAR	_	VM O		spiratory arres	st,	Approximate Interval Between Onset and Death 2 WFEKS
ľ	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	o (or as a consec CND o (or as a consec	STAC	E C			RUCTIV		10 YEARS
1760	ite be executed ysician and ne burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due t	o (or as a conse	quence of):			ULM OF	NAKY I	DISEASE	
O. Box 68	es that the death definicate grant to the tending physical by the attending physical be detached for use as the t	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	outcome of pregn birth 2 Pet gnant at time of known	al death 3	□Ectopic pregnan □ Other (specify)	су			23d. Date of deli Month	very Day Year
ds, P	uries that n signed to	d by P	Part II. Other significant condit	^ -	death but not re		underlying cause o	iven in Part	l. 	23e. Did toba	acco use contribute to s 2 ☑ No 3 ☐ Pr	the cause of death?
l Record	The law requires	Completed								24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of 2 No
nof Vita	ding Physician: The large Physician: The large Physician The Large Partition of the large P	To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Wastural 5 Pend	Hospital: 1 [Inpatient 2 [te of Injury onth, Day Year)	ER/Outpatie	nt 3 DOA	ther: 4 DM	ursing Home		nce 6 Dother (Spec winjury occurred	sify)
Division	or Attandated death Director:	Certification;	2 Accident inves	igation I not be 28e. Pla	ce of Injury - At t Iding, etc. (Spec	nome, farm, s	M 1]Yes 2[e	No 28f.	Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
2//2	the Hospital	Medical C		Examiner: On the							use(s) and manner as te and place, and due	
7	within comp	M	29b. Signature and title of certification of the second se	, Path	uman	9 , M	D DE	1952			d. Date signed (Monti	3,2004
-			30. Name and address of perso 40 VEEN PUT 31. Date filed (Month, Day, Yea	HUMAN	A 3110	GRA	CEFIEL	D RO	AD SI	LVERS	SPRING,	MD 20904
	St Regist	ate rar	MAR 0		Registrar's Sign	5	Spark	N				

		1	For State	State of Ma	ryland / D	epartme Certifica	nt of Health and te of Death	Mental Hyg	iene 2004	09601
	4		Registrar 1. Decedent's Name (First, Middle, in the control of th	Last)				2. Date of Deat		3. Time of Death
	Physicia	an	ELIGIE	GIL	L .	Jr.		MARCH	Day Year 6 2004	1714. M
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City	, Town, or Location of Dea	ath	4c. County of Death	1
	Examin	eı	Shady Grove		Hospi	tal	Rockville		Montgon	
	Funeral Director	1	5. Social Security Number 411-74-5348	57	(In yrs. last birth	rs. If Undi	or 1 Year If Under 24 Hi Days Hours Min		Year) 1945 Ten	iplace (State or Foreign Intry) INESEE
	Б		Usual Residence of Decedent		10c. City, Town	as Legation			T	10d. Inside City Limits
	arylar show		10a. State 10b. County							1. Yes 2 □ No
	8a-f	Director	TN Gibso)II	Hum	boldt	ip Code	11	Og. Citizen of What Cou	untry?
	with the	급	10e. Street and Number 651 Humbold	- Gibson W	ills R		38343		U.S.A.	•
	eath 's 23	erai	11. Marital Status	12. Was Decedent E		13. Was Dec	edent of Hispanic Origin?	(Specify Yes or No-	14. Race - Amer	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show important: if item 27 is marked other than "natural", or items 23a or 28a-f show any july yo other traumatic event, Ina Medical Examinar must be notified at ange.	Fur	1 ☐ Never Married 2 🖾 Marrie	If Yes, Give	0		ecify Cuban, Mexican, Pue 2 No Specify:	erto Rican, etc.)	Specify: B	ack
21215-0036	hours tural',	d by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:	16a.	Decedent's Us	ual Occupation		16b. Kind of Business/l	
7	in 72 inal	olete	(Specify only highest	grade completed)		(Give kind of w life. DO NOT	ork done during most of w	and the second	Long Dist	ance
212	with jiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	T T	ruck	Driver		Transpor	ctation
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, La					lame (First, Middle, M		
/lar	Menta Menta Menta Mrkad Mrkad	일	Elijah (Gill		<u>-</u>			ncaster	
Maryland	2 sho and ! is me		19a. Informant's Name/Relationship			_	ss (Street and Number or			
	and lealth m 27 her tr		Lee Nolar Gil	l- Wife		51 Hull Disposition (N	mbolt Gibs		IMDOLOT, 120c. Location - City or 1	
ore	H ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemeter	v, crematory of	other place)		Humboldt	
Ξ	tent:		'4 □Donation 5 □ Other (Spe 21 gnan re of Funeral Service Li		Baske					
Baltimore,	Depar mpor mpor mny ir		21 Ignature of Funeral Service Li	censee	and net		N Washingt		Funeral E	
			23a. Part 1. Enter the disease, or c	omplications that caused	the death. Do n					Approximate
			shock, or heart failure. List o	nly one cause on each line	ocard	lial	Infarction	4		Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	_ a	consequen # c	of): ^	Todas Cisos	4		aring KS
	Examiner			H	- A	usid	h			years
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a		W = 1	,			1020
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	· Kei	rock of	ecilu	up			4this
Ő,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a	consequence o	M):				
8760,	certificate be executed nding physician and use as the burial-transit	edical	•	d						
9 x	Jeath certifica attending ph	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date of deli	verv
Вох	ath	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 3	2 🗌 Fetal death	3 Ectopic 5 Other			Month	Day Year
o.	0 0 2	ysi	1 Yes 2 No 9 Unknown	9□Unknown						
٣.	res that the signed by th be detache	by Pł	Part II. Other significant condition	s contributing to death bu	it not resulting in	the underlying	cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
rds	w requires been sign should be							1 Y	es 2 No 3 Pro	obably 4 Hiknown
000	> 10 10	Completed						24a. Was a autops		topsy findings available completion of cause of
Ä	9 4 9	E O						perform	med? death?	2□ No
Vital Records,	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?			-		Death Check on on	18	
of V	y s	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie					ence 6 Other (Spec	city)
	ding Ph th. After th funeral	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 28b. T	ime of njury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
sio	Attending r death. ector: After by the fune	cat	2 Accident investigation inves		ny - At home fa			28f Location (Si	treet and Number or Ru	ral Route Number.
Division	l or Atten after deat Director:	Certification:	4 Homicide determin	28e. Place of Inju- building, etc	. (Specify)	iiii, 3(1991, 1401	ary, omos	City or Town	n, State)	
_	To the Hospitel or A within 24 hours after To the Funeral Dire		29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of taminer: On the basis of	examination an	e, death occurre	ed at the time, date and pla on, in my opinion, death of	ace, and due to the c	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the H within 24 To the F	Medicai	one) 29b. Signature and title of certifier	and manner sta			29c. License number		9d. Date signed (Monti	n, Day, Year)
	L W L		290. Signature and little of certifier	1 - h	W	1	V			6th, 2004
•	2		on Name of the Control of	the completed and a	eath (Itom 22a)	(Type Print)	7110		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 7
			30. Name and address of person v	vho completed/cause of de	HUY	990	Medica	l center	March Drive h	oclarille MD
No.	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	4 1.	na Val			

		1	For State Registrar	State	of Maryla		artment rtificate			ind M		Reg. No.	004		602
	Physicia		Decedent's Name (First, Middle	Last)							2. Date of De Month	ath Day	Year	3. Time of	_
	/Medic	al .			ERTLER		45 O.5. 3		I continu	4 Dansh	March	4	2004 inty of Death	184	1-101
	Examin	er	4a. Facility Name (If not institution,	_		TON		KVII	Location o	Death			TGOME	οv	
			HEBREW HOME OF 5. Social Security Number	6. Sex		LON . last birthday)	If Under	1 Year	If Under 2		8. Date of Bir	th	9. Birth	place (State o	or Foreign
	Funeral Director		578-90-9540	1□M 2□F	98	Yrs.	Months	Days	Hours	Min.	OCT 1,		ILL]	ntry) LNOIS	
	ō		Usual Residence of Decedent											10d. Inside Ci	ib. I imito
	arylar show	-	10a. State 10b. County		100.0	ity, Town or L								1 □Yes	
	Ba-f	ecto	MARYLAND MONTG	OMERY		BETHI	ESDA 10f. Zip	Codo				10a Citizen	of What Cou	Λ_	
	a or 2	吉	10e. Street and Number 7420 WESTLAKE T	FDDACE	# 8∩5		101. ZIP		0817			UNITED			
	within 72 hours atter death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Expedies must be nutilised at	Funeral Director	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Deced	ent ol Hi	spanic Orio	gin? (Spe	cify Yes or No	j- 14. I	Race - Ameri	can Indian,	
က	or Iter		1 Never Married 2 Marri	ed 1 ☐ Yes	Forces? 2 X No		Il Yes, spec 1 ☐ Yes 2		n, Mexican Specify:	, Puerto	Hican, etc.)		Black, White,	etc.	
ё О	ral', o	1 by	3 Widowed 4 ☐ Divorced	If Yes, C Year or	Dates:		1 Hes 2	MI NO	<i>эр</i> еспу.			Spe	ecify: 	WHITI	3
215-003	72 h natu	Completed	15. Decedent (Specify only highes	s Education t grade completed	d)	(Give	dent's Usua kind of wor DO NOT us	k done c	turing most	of worki	ng	16b. Kind o	of Business/Ir	ndustry	
	within ne. then	dm	Elementary/Secondary (0-12)	College	(1-4 <i>o</i> r 5+)		DO NOT BS	-	,				WN HON	Æ	
d 21	fited Hygie other		17. Father's Name (First, Middle, I	ast)		1 111	AILI IIII		18. Mothe	r's Name	(First, Middle			111	
au	d be ental ked o	To Be		BERMAN					RI	EBEC	CA		MAN	1	
Maryland	2 should and Men is marke aumatic	-	19a. Informant's Name/Relationsh	iip (Type, Print)			•				l Route Numb	-		o Code)	
	permit. Pages 1 and 2 should be fited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show ampringly or other traumatic event, the Madical Examiner must be notified at App.		DONALD E. GERTL 20a. Method of Disposition	ER, SON	20b.			-			ETHESDA Date		20817 on - City or T	own, State	
Baltimore,	Pages nent of H		1 Warial 2 Cremation		m State	Place of Disponentery, cre			-						ATTA
턆	permit. Page Department of Important: If any injury or once.		*4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service I		В	'NAI I	2 Name and	d Addres	e of Facilit	V	1271-147				עוא
Ba	permi Depa Impo any ii		Donald (". Ot	Atten	uer D	ANZANS 1170 R	KY-(OLDBI TLLE	ERG I PTK	MEMORIA E. ROCK	L CHAP VILLE.	ELS, I	LNC. 20852	
· ·			23a. Part1. Enter the disease, or shock, or heart failure. List	complications tha	t caused the de									Approximat Interval Bet	e ween
	Pnysician		Immediate Cause (Final disease or condition	,	14.75	sclen	120				Vood		11	Onset and I	Death
	/Medical		resulting in death)	Due t	to (or as a conse					1					
Š,	Examiner		Sequentially list conditions,	b											
	ped tist	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o (or as a conse	equence on.									
	icate be executed physician and s the burial-transit	xar	that initiated events resulting in death) Last	c. Due t	to (or as a conse	equence of):									
760,	ysiciar je buri	cal		d									F.11		
89	tificati ig phy as the			3.											
Box	death certifica e attending ph id for use as th	N/U	IF FEMALE: 23b. Was decedent pregnant		outcome of preg		⊒Ectopic pre	egnancy				23d.	Date of deliv	,	Year
		sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (spe						Month	Day '	1 841
P.O.	at the	Physician/Med	9 ☐ Unknown Part II. Other significant condition			oulting is the	and others of		on in Part I		23e Did	tobacco use d	contribute to	the cause of o	heath?
ŝ	The law requires that the death certific that been signed by the attending page 2 should be detached for use as	by	Part II, Other significant conduct	ins continuuming to	o death but not re	ssummy in the t	andenying Ca	ause give	eri ili raiti.			Yes 2□N			Unknown
orc	w requir	Completed		v							24a. Was	200		opsy findings	available
3ec	ne law has l	Id III					<u>-</u>				auto perfe	psy ormed?	prior to co death?	empletion of c	ause of
al		ပို့ ပို	25. Was case referred to medical						00 81	-4 D4	1 Yes		1 🗆 Yes	2 No	
of Vital Records,		00	examiner?	Hospital:	☐Inpatient 2	☐ ER/Outpatie	nt 3 DO	A Oth	200	-	n <i>(Check only</i> me 5 ☐ Resi		Other (Speci	(v)	
		n: To	27. Manner of Death	28a. Da	te of Injury onth, Day Year)	28b. Time o		8c. Injury Work	at	-	28d. Describe			.,,,	
<u>io</u>	Attending r death. sctor: Afte by the tune	atlo	1_Natural 5 Pendin 2 Accident investig	gation	onin, ouy rour,	,ury	М		Yes 2 🗆	No					
Division	or Attend after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could in determine	inad 288. Pla	ice of Injury - At ilding, etc. (Spec		treet, factory	, office			28f. Location (City or To	Street and Ni wn, State)	ımber or Rur	al Route Num	nber,
0	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the		29a. Certifier 1 Certifyin	g Physician: To	the best of the	nowledge de-	th occurred	at the ti-	no data a-	d place	and due to the	oauga/a\ ==	l mannor or	etated	
	Hospital 24 hours a Funeral C	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examination basis of examination of the basis of examination of the basis	nation and/or i	nvestigation,	in my o	pinion, dea	th occurr	ed at the time,	date and pla	ce, and due t	the cause(s	;)
	To the To To To To To To To To To To To To To	Me	29b. Signature and title ol certifie	ſ	/-				number				gned (Month,		
)	1		Consent	1	way	14		D: 4	1490	>		Mar	ch S	5, 20	04
	7		30. Name and address of person			em 23a) (Type	, Print)	Con	SUE	0	12	mar	2, 1200	?	
			6105	Mont		Rua	d,	R	OCK	11/6	M	ma	′2_	085	2_
	Sta Regist		31. Date liled (Month, Day, Year)	2004 32	. Registrar's Sig	nature 4	Sp	ark.	2						

		1 - For State Registrar	State of Marylan	id / Depa	artment rtificate	of He	ealth ar Death	nd Me	ntal Hy	gien Reg. N	^e 2004	09	603
Physic		Decedent's Name (First, Middle, Last, MARIA GENOVEVA						2	Date of De Month March	aath D	av Year	3. Time o	
/Med Exam		4a. Fecility Name (If not institution, give			4b. City, 1	Town, or I	Location of I				c. County of Death		
		18410 Autumn Fiel	d Court		Воу	ds]	Montgome	ry	
Funera Directo		5. Social Security Number 6. Se 213-35-3918	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	Date of Bir (Month, Da an. 1		9. Birth 939 E1 S	place (State intry) alvado	
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the and Mental Hygiene. It has a marked other than "naturel", or tiems 23a or 28a-f show other traumatic event, the Madical Entrolling I and Le inclined at	Director	10a. State 10b. County Maryland Montgome		ds				·					City Limits 2⊠No
with t	ä	10e. Street and Number	_		10f. Zip						itizen of What Co	untry?	
leath	Funerai	18410 Autumn Field	12. Was Decedent Ever in U	.S. 13.	208 Was Decede		panic Origin	n? (Specif			Salvador 14. Race - Amer	ican Indian.	
after or their	T.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐XNo		Was Decede						Black, White		
ours a	Š	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊠ Yes 2	2 □ No	Specify: E1	Sal	vadori	ian	Specify: W	hite	
72 h	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece (Give	dent's Usual kind of worl DO NOT use	I Occupat	ion			16b.	Kind of Business/l	ndustry	
Mathin 100.	mom	Elementary/Secondary (0-12)	College (1-4or 5+)		_	e retired)							
Hygie Hygie ther t				Homen	aker		18 Mother's	s Name //	First Middle		n Home		
d be formal hand of	Be					:				, maios	n Sumame)		
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, trans	٥	Manuel Garcia 19a. Informant's Name/Relationship (T)	rpe. Print)	19b. Maili	na Address	(Street au	Marta Marta			er City	or Town, State, Z	in Code)	
and 2 sealth ar n 27 is			Son)								ille, MD		
s 1 and 1 f Health ftam 27		20a. Method of Disposition	20b. F	place of Dispo	sition (Nam	e of		Dat			Location - City or T		
permit. Peges Department of Important: if the	p	1 ☑Bunal 2 ☐ Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	Souls				/8/20	104	Corr	mantown,	Marril.	an d
permit. Departm importa	ė	21. Signature of Eugeral Service Licens		22	2. Name and	d Address	of Facility	DeVo	1 Fun	era	l Home	магута	111U
a a a E a a	1	Voterto & a	West								rsburg, N	id. 208	377
Physiciar /Madiso	_	23a. Plart 1. Enter the disease, or complete, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Portal Hyper	tensio		of dying	, such as ca	ardiac or r	espiratory a	rrest,		Approxima Interval Be Onset and 6 Mont	tween Death
/Medica Examine		1	Due to (or as a conseq										
	100	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq						-				,
petr f insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	, , , , , , , , , , , , , , , , , , , ,										
be executed sicien and burial-transit	EXa	resulting in death) Last	Due to (or as a conseq	uence of):									
e be ex	cai		1										
tificat ng phy as th										1			
The law requires that the death certificate I are has been signed by the attending physicage 2 should be detached for use as the la	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2X□No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	⊒Ectopic pre ⊒ Other (spe						23d. Date of delin Month	,	Year
that hed by deta			ntnbuting to death but not res	ulting in the u	nderlying ca	use giver	n in Part I.		23e. Did t	tobacco	use contribute to	the cause of	death?
quires n sigr	yd by								1 🗆	Yes 2	2 □No 3 □ Pro	bably 4 🔀	Unknown
w requ	Completed								24a. Was	an	24b. Were aut	opsy findings	available
The life has age 2	I III O							_		ormed?	death?	ompletion of a	ause of
cian: Tean: Sertifica	a	25. Was case referred to medical					26. Place of	f Death (1□ Yes Check only o		o 1 Tes	2 <u>₹</u> 1140	
Physician: The law this certificate has b	ToB	examiner? 1 ☐ Yes 2 ☑ No	fospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 DO	Othor	-				6 ☐Other (Spec	fy)	
tanding Ph death. tor: After th		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28	Bc. Injury Work	at	280	d. Describe	how inju	ury occurred		
andir sath. or: Al	atic	2 Accident investigation			М		es 2 □ No	>					
D P P P	Certification:		28e. Place of Injury - At h building, etc. (Specif	(y)					City or To	wn, Stai			nber,
To the Hospitel or within 24 hours afte To the Funeral Discompletely filled in	Medical	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ition and/or in	vestigation,	in my opi	nion, death	place, and occurred	d due to the at the time,	cause(s date ar	s) and manner as nd place, and due	stated. to the cause(5)
To t To t	Σ	29b. Signature and title of certifier	010		29c.	License	number			29d. D	ate signed (Month	Day, Year)	
10		Mahreth	Hussa	n	D	006	0050		M	larc	h 5, 200	4	
10		30. Name and address of person who co						_					
		Dr. Mahrukah Huss 31. Date filed (Month, Day, Year)		21 Mer	chanti	ile I	Jane	Lar	go, Mo	d.			
S Regis	tate strar	MAR 0 9 200	32. Registrar's Signa	ALUIFO LA	100	uks	/						

	•	•	For State Registrar	State of	Mary	land / Depa <i>Ce</i>	artmen rtificate	t of H e <i>of L</i>	ealth a D <i>eath</i>	and M	ental Hyg	iene 2 (004	09604
	Dhysisi		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	3. Time of Death			
	Physicia /Medic		James Brandon Hassell								March			03:11AM
	Examin	er							Location o	f Death			ty of Death ≟ ⊓	
	F		Union Hospital 5. Social Security Number 6. Sex		7. Age (In	yrs. last birthday)	If Under		If Under	24 Hrs.	8. Date of Birth	Cec		place (State or Foreign
	Funeral Director			M 2□F	54	Yrs.	Months	Days	Hours	Min.	(Month, Day AUG 1,	Year)	Court	ntry) nessee
	pu ,	Ì	Usual Residence of Decedent 10a, State 10b, County		100	c. City. Town or Lo								
d 21215-0036	laryla shov	5			100	North E								0d. Inside City Limits 1 ☐ Yes 2 🖫 No
	the N 28e-1	Director	Maryland Cecil 10e. Street and Number			NOLUI	10f. Zip	Code			1	0g. Citizen of	What Cour	
	3a or	0	2606 Biggs Highwa	V				1901					ed Sta	•
	death	Funeral		2 Was Dece	dent Ever	in U.S. 13.			spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Ra	ice - Americ	ean Indian,
9	or Ite	y Fu	1 X Never Married 2 ☐ Married	Armed For 1 X Yes If Yes, Give Year or Da	2 Not 2	969- 975	1 ☐ Yes 2		Specify:	, rueno i	tican, etc.)	Speci	ack, White,	
ğ	hours turel',	ed by	3 Widowed 4 Divorced		tes:							16b. Kind of E	Whi	
7	in 72 n "na Nedic	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)							ng	Fabric			
212	d with giene. rr thai	mo:	Elementary/Secondary (0-12)	College (1-	40r5+)	Che	mical	Tec	hnici	an		and Co	ating	
p	9 7 5	Be C	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Suma	me)	
<u>X</u>	ages 1 and 2 should b nt of Health and Ment t: If item 27 is marked / or other treumatic e	2	Edward Thomas Has							-	e Strou			
Mar	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Type Wayne D. Hassell/								Route Number			
e,	1 and 2 Health tem 27 i		20a. Method of Disposition	brotne	20	h Place of Disno	sition (Nam	ne of		D	Elkton,	Mary La 20c. Location		
ğ	Pages nent of int: If it iry or o		1 ⊠ Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from S	State	Gilbin M	natory or of anor	her place	e) ¦M	arch	22,			
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		21. Signa ure of Funeral Service License	e) .	1.12	Memorial	2. Name and	d Addres	s of Facility	004_ L		Elkton	Mary	Tand
ñ	Per Per Per Per Per Per Per Per Per Per		1. Namiel S.	Du	ad	H:	icks b 03 W.	lome Sto	ior . ckton	tune: Stre	cals, P	.A. ston. N	Maryla	and 21921
	Pnysician /Medical Examiner	ilner	23a. Pant Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Unorfair	Due to (c	ich line. Lute or as a cor	nsequence of):					•	est,		Approximate Interval Between Onset and Death Tunn adjute
Box 68760	that the death certificate be executed so by the attending physician and detached for use as the burial-transit	Physician/Medicai Examiner	that initiated events resulting in death) Last	Due to (d 3c. If yes, outd 1 □ Live bi	ome of pr	Fetal death 3	Ectopic pre						ate of delive	iry Day Year
O	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregna 9□Unkno		ofdeath 5∟	Other (spe	ecify)						
rds, P.	8 5 8	by	Part II. Other significant conditions con	tributing to de	ath but no	t resulting in the u	nderlying ca	cu/	-	's eas				ne cause of death? ably 4 □Unknown
000	aw requir is been si 2 should	Completed	,		,	•					24a. Was a		Were autor	osy findings available inpletion of cause of
Ĕ	The ate he	E O									perforr	ned?	death?	
ita	cien: ertifici octor,	Be (25. Was case referred to medical examiner?							of Death	(Check only on	θ)		
5	shysic this o	P.	1 ☐ Yes 2 🗷 No			2 X ER/Outpatier		-	4 U Nui	_	ne 5 ☐ Reside			<i>'</i>)
Division of Vital Records,	ttending f death. ctor: After y the funer	Certification:	27. Manner of Death 1 Statural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury Work? M 1 ☐ Yes 2 ☐ No						28d. Describe how injury occurred				
Σ	el or Al s after o al Direc	Certif	3 Suicide Su									i Houte Number,		
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 CCHeck only one) 1 CM Certifying Physical Examination 1 CM Certifyin	ician: To the ler: On the ba and mann	sis of exar	knowledge, death mination and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a h occurre	nd due to the ca d at the time, d	use(s) and mate and place,	anner as sta and due to	ated. the cause(s)
	To t withi To tl	Ž	29b. Signature and title of certifier				29c	License	number			9d. Date signe		
	1/1		1 Jurkas,	MD				15	314	+	/	March	20,	2004
1	1,		30. Name and address of person who co	mpleted cause	of death	(Item 23a) (Type,	Print)	Ktor	1. /	~ D				
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 9 20	04 32. F	gistrar's S	ignature	porti	,	,					

State of Maryland / Department of Health and Mental Hygiene 09605 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician AM MARIA A HERNANDEZ MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner INSPITAL HOWARD HOWARD COUNTY GENERAL COLUMBIA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🛱 F 64 Director 08-16-1939 El Salvador none Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23s or 28s-f ahow The Medical Example of must be notified at 10d. Inside City Limits XXYes 2 No Howard County Columbia Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9806 Davidge Drive 21044 El Salvador Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 XYes 2□ No Specify: Salvadoran þ If Yes, Give Year or Dates: White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. 2nd Homemaker Own Home item 27 is marked other other treumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental Jesus Hernandez Fernanda Amaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Hernandez - Son 9806 Davidge Drive Columbia, Maryland 21044 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Family Cemetery 03/18/2004 San Alejo, El Salvador permit 21. Signature of Funeral Service Licensee 22. Name and Address of Facilty. H. Bacon Funeral Home, Inc. 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPTIC Physician SITUCIC 72 HRS resulting in death) /Medical Due to (or as a consequence of): Examiner 5 DAYS CENTRAZ LINE INGECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) sician Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ☐Yes 2 KNo detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ should be 152000 months TRATUREORNING CHITES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been CELL LYMPITOMA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 XNo 24a. Was an has page 2 certificate 1 Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 Dinpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation after death. 1 ∏ Yes 2 ∏ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pletely filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the h and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 036974 3/8/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MULHAPIN.O 10724 LITTLE PATURISHT PKNY CountriA mo 21544 DAVID 31. Date filed (Month, Day, Year) MAR 1 0 2004 32 Registrar's Signature State Con and Registrar

			For		nd / Depa	artment of H	lealth and M	Mental Hygi	ene				
			1 - State Registrar		Ce	rtificate of	Death		g. No. 200				
	Physicia		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death			
	/Medic						 	March 11		3:30 a M			
	Examin	er		An Norbury Hebrew In Hebrew In Norbury Hebrew In Norbury Hebrew In Hebrew In Norbury Hebrew In Hebrew In Norbury Hebrew In Hebrew In Norbury Hebrew In Hebrew In Norbury Hebrew In Hebrew In Norbury Hebrew In Hebrew In Norbury Hebrew In Norbury In Norbury Hebrew In Hebrew In Norbury In Hebrew In Heb	1	4c. County of De							
					het histochul			8. Date of Birth		irthplace (State or Foreign			
	Funeral Director		579-05-9876					Dec. 31,	Year) 1916 Wa	shington, DC			
7	2 *	}	Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits			
1	a b	5	Manualand Prince G	oorge's H	vattevi	11e				1∭Yes 2□No			
4	28a-	Director	10e. Street and Number	20180 0 11.	, 400012	1		10	g. Citizen of What C	Country?			
4	Jo ag		6207 Sargent Road			2078	32		U.S.A.				
4	ms 2	Funeral		12. Was Decedent Ever in	U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-		nerican Indian,			
	s Tand 2 should be fined within 72 hous also death with the waryand teath and Mandal Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, the Medical Expiritive must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖫 Wildowed 4 ☐ Divorced	1 ŽAYes 2 □ No lfYes. Give WT					Black, White, etc. Specify: White				
5	ature	Completed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	1	6b. Kind of Busines	s/Industry			
7		ple	Elementary/Secondary (0-12)				d)	i i		and the			
7	er th	PO.		2		U.S. Gove	ernment						
	and Mental Hygiene. Is marked other than aumatic event, tra M.	To Be (17. Father's Name (First, Middle, Last) John Alexander He	brew III		me (First, Middle, Maiden Sumame) nce Soper							
	trauma					*	Street and Number or Rural Route Number, City or Town, State, Zip Code)						
י עב	Health Hearn 27 Sthar to	1	20a. Method of Disposition			or Town, State							
	permit. Pages Department of Important: If it any injury or o		1 Burial 2 Cremation 3 R	12/2004	2/2004 Alexandria, Virginia								
	artme ortan injur		21. Signature of Funeral Service Licens										
Ö	Per Per Per Per Per Per Per Per Per Per		Helan L. To	hill.									
	NT AS		23a. Part1. Enter the disease, or compli	cations that caused the de	ath. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between			
0.0	huaiaian		Immediate Cause (Final	le cause on each line.	n h. : 00					Onset and Death			
- 5 - 1	hysician /Medical		disease or condition resulting in death)	Due to (or as a consc	equence of):	<u></u>			, 1				
, E	Examiner			End S	Tago	Chrin,	· Cong	estille	Jailley	1 year			
	W.	ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	4								
	w fequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Examiner	that initiated events	Covono		2 Very	elisa	edse_					
, 0	e be executed /sician and e burial-transi		resulting in death) Last	Due to (or as a conse	1								
	ate Di	Icai		1. They	Lifts.	mil							
Ď !	cerninca nding phy use as th	Physician/Medi	IF FEMALE:										
Š	death ce	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fe	etal death 3		1		23d. Date of d Month	elivery Day Year			
	the a	sic	1 ☐ Yes 2 X No 9 ☐ Unknown		rdeath 5L	_ Other (specify) _							
	requires that the	Ph		ntributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?			
cords,	sign d be	l by						1 ☐ Yes	2 DNo 3□1	Probably 4 Unknown			
Ö	been been shoul	ompleted						24a. Was an	24h Word	autopsy findings available			
75	Ine law ate has b page 2 sl	mp						autopsy	prior to	completion of cause of			
	certificate has rector, page 2	O						1 □ Yes 2	No 1 □Ye	es 2 No			
VITA	ysicien: is certific director,	Be	examiner?	lospital:		Oth	OC.						
ō :	rthis ral dir	: To	1 Yes 2 No	28a. Date of Injury	28b. Time o	III 3LI DOA	4 Nursing n		Describe how injury occurred				
0	ding Phy h. After thi funeral o	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Wor	k? Yes 2∐No							
DIVISION	l or Attanding Physicien: after death. Director: After this certification by the funeral director.	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, street, factory, office						Rural Route Number,			
5	after Dire	erti	4 Homicide	building, etc. (Spec	cify)	·		City or Town,	State)				
	e Hospitel or Attan 24 hours after deatl a Funaral Director: etely filled in by the	calC		sician: To the best of my kiner: On the basis of exami									
	he H in 24 ha F plete	edical	one)	and manner stated.									
	To the within 2 To tha complete	Σ	29b. Signature and title of certifier	0 2 0		29c. Licens	3 3 3 9	29	d. Date signed (Mor	nin, Day, Year) /*			
0			1 Janual C	Lanchian		01	/		110/04	•			
4	5)1kg		30. Name and address of person who co	Impleted cause of death (It	em 23a) (Type	24 C	anning,	ham Dr.	ive, Bu	rug Height			
	Sta	te	31. Date filed (Month, Day, Year) MAR 1 2 2004	2. Registrar's Sig	nature								

			1 - For State Registrer AMEND#7penFH3 1. Decedent's Name (First, Middle, La						Death	2. Date of De	Reg. N		04	09607	
	Physici /Medic		~ .	D.	Ну	son				Month			ear 4	2:55AM M	
	Examin		4a. Facility Name (If not institution, giv						r Location of Dea	ith		c. County of			
		1	7407 Honeywell La 5. Social Security Number 6. S		e (in yrs. lasi	t birthday)	If Unde	hesda r 1 Year	If Under 24 Hr	s 8. Date of Bi		ontgo		lace (State or Foreign try)	
	Funeral Director			™ 2□F	87 8	8 Yrs.	Months	Days	Hours Mir	s. 8. Date of Bi (Month, Di Dec. 29	0, Year	915	Coun M	aryland	
land	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or Lo	cation					10d. fnside City Lim			
e Mary	de l'es	ctor	Maryland Montgon	nery	Ве	thesd	a							1 ☐ Yes 2 🛣 No	
with th	a or 28 De rio	Director	10e. Street and Number 7407 Honeywe11	Lane			10f. Z	p Code	20814		_	itizen of Wh nited		•	
3-UUSO 72 hours after death with the Maryland	ial Hygiene. d other than "natural", or itema 23a or 28a-f show event, Ita Mudical Exactivar must be rotified at	y Funerai	11. Marital Status 1 □ Never Married 2∑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give			Was Dec f Yes, sp		lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		14. Race	America White, 6	an Indian,	
2 hour	atural Ical Ex	ted b	15. Decedent's E	Year or Dates:	1	16a. Deced	lent's Us	al Occup	ation during most of w	ortrina	16b. l	Kind of Busi			
filed within 7	han "r s Med	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L		nomi:		Jiking		C+a+	n Do	partment	
Z DI	nd Mental Hygiene. marked other than matic event, ILS M	Be Co	17. Father's Name (First, Middle, Last,				Lico	HOME		ame (First, Middle	, Maide			partment	
Maryland 21215-0036 d 2 should be filed within 72 hours af		To B	, ,	son					Rose	Mil1					
and 2 sh	of Health and Meritem 27 is marker other traumatic		19a. Informant's Name/Relationship (Winifred P. Hys	**			_			Rural Route Numb , Bethes					
v – :	of Hea fitem fother		20a. Method of Disposition	Removal from State	20b. Plac	e of Dispo				ch ^{ate} 10,	_	ocation - C			
Baltimore,	Department of Important: If it any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specif		Chesa	apeak				004	В	e1tsvi	111e	, Md.	
n ed	Depar Impor		21. Signature of Funeral Service Licer	Thoday.	2261		Rap 933	p Fur Gist	ss of Facility neral an t Ave.,	d Cremat Silver S	ion pri	Servi	ces 1. 20	0910	
Ph	ysician		23a. Part T. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition		the death. I ne. noma of			de of dyir	ig, such as cardia	ac or respiratory a	irrest,			Approximate Interval Between Onset and Death 4 Months	
	Medical aminer		resulting in death) Due to (or as a consequence of):												
y A	* *	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):												
J, executer	al-trans	xami													
58/50, flicate be executed	physician and is the burial-transit	edical		d											
Geath cert	uttending or use a	Physician/Me										23d. Date Month		,	
that the	signed by the a		9 ☐ Unknown Part II. Other significant conditions of	contributing to death b	ut not resultir	ng in the ur	nderlying	cause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?	
ecords,	been sign should be	ed by	Metastatic Pro	state Canc	er					10	Yes 2	2 ∑ No 3	☐ Proba	ably 4 Unknown	
E #	ite has	Pletastatic Frostate Cancer 24a. Was an autopsy prior to comple death? 1 Yes 2 \nabla No 1 Yes 2										osy findings available apletion of cause of 2 No			
VITAL M	certificate irector, pag	o Be	25. Was case referred to medical examiner?	Hospital:		1/0-4		Oth	or	eath (Check only		a 🗆 🗆			
n OT	th. : After this certifica i funeral director, p	H-	1 Tes 2 No 1 Inpatient 2 EN/Outpatient 3 DOA 4 Ni							Home 5 MR Residence 6 □ Other (Specify) 28d. Describe how injury occurred					
DIVISION OF VITA	the	Certification;	1 Matural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 4 Hom								nd Number te)	or Rural	Route Number,		
Hospital	 within 24 hours after of To the Funeral Direct completely filled in by 	edical Ce		nysician: To the best miner: On the basis of and manner sta	examination										
To the	To the	Me	29b. Signature and the of certifier	11	~~		25		e number		29d. Da	ate signed (Month, E	Day, Year)	
ě	+		Herry y	ulhu	14.6	2		 1U	3818		3/	19/0	27		
			30. Name and address of berson the Gary P. Fisher,	M.D.; 553	eath (Item 23	a) (Type, consir	Print) 1 AV	e., C	hevy Cha	ase, Md.	208	15			
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	B	de	ook.	2						

State of Maryland / Department of Health and Mental Hygiene 2004 09608 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February Year **Physician** 1510 18 2004 James Felman Harrison, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Chowerly Hospital Georg George 5 If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year Sept. 11, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Sex 14 M 2 ☐ F **Funeral** Year) Months 1955 South Carolina 577-76-4654 48 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State in than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at X☐Yes 2☐No Maryland Prince George's Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9001 Cherry Lane 20708 United States 12. Was Decedent Ever in U.S.
Armod Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 1980 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Courier Bike Courier permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier Important: If Item 27 is marked other th any injury or other traumatic event, Im once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James F. Harrison Elizabeth H. Bowie 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca Carswell (sister) 8904 Maine Ave. Silver Spring, MD 20910 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 3/12/04 Cheltenham, MD Maryland Veterans * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service noson 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Head Injung with Complications Clesed years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner inding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | is certificate has been signed by the a director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner! 70 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred the ingles of the bit of the bit of the control of the bit of the control of the bit of the control of the bit of the control of the bit of the control of the control of the bit of the control of the bit of the control of the bit of the control of the bit of the neral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 5 Pending 1 Natural :30 M 1 ☐ Yes 2 ☑ No death. investigation WAM 13, 1995 5 2 Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street am Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 4 Homicide STrey WAShington Avenue 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie within 24 hor To the Fune completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Salvador 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sylvete 300/ 100 ital 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 08 2004

			. For		of Marylar	nd / Depa	artme	ent of H	ealth a		-	gien	e _		0.0	
			1 - State Registrar			Ce	rtifica	ate of L	Death		O Data of D		ه ۷ ا	104	US	609
	Physici	an	Decedent's Name (First, Middle, L.								2. Date of De Month	D	ay	Year	3. Time	of Death
	/Medic	al	Dorothy B. 4a. Fecility Name (If not institution, g.			_	4b Ci	ty, Town, or	Location of		March		2004 c. County	of Death);).	J A
	Examin	er	Mornig Side House		ambony			icott					•	l Cour	ntv	
	Funeral			Sex	7. Age (In yrs.	. last birthday)		der 1 Year	If Under 2		8. Date of Bi (Month, D					or Foreign
for Sign	Director		074-14-2055	1□M 2 X)F	82_	Yrs.	I VIOITE	Days	110010		June 6			New '		
	and		Usual Residence of Decedent 10a, State 10b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside	City Limits
	Maryli f sho	ŏ	M1 1 II1			7114	- 03								1 💢 Ye	s 2 No
	roun	Director	Maryland Howard 10e. Street and Number			Ellicot		Zip Code				10g. C	itizen of \	What Coun	try?	
	h with		5330 Dorsey Hall	Dr.			21	.042				U.5	S.A.			
	ems erm	Funeral	11. Marital Status	Amed		J.S. 13.	Was De If Yes, s	cedent of Hi pecify Cuba	spanic Orig	gin? (Spe , Puerto	cify Yes or N Rican, etc.)	D-		e - Americ ck, White,		
36	s afte	by Fu	1 Never Married 2 Married X Widowed 4 Divorced	1 Tes	27∑No Give		1 🗆 Yes	2 X No	Specify:				Specify			
Ö	be filed within 72 hours after death with the Maryland hal Hyglene. od other than "natural", or Items 23e or 28e-1 show event, the Medical Exactinar must be profiled at	ed t	15. Decedent's		Dates.			sual Occupa				16b.	Kind of B	Whi usiness/Ind		
715	nin 72	piet	(Specify only highest g Elementary/Secondary (0-12)	rade completed	(1-4or 5+)	(Give	kind of DO NO	work done o Luse retired	during most)	of worki	ng					
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nd	be filed tal Hygi d other	Be	17. Father's Name (First, Middle, Las	:t)							(First, Middle		n Suman	10)		
yla	should by ind Menta ind marked umatic ev	2	Abraham Baskin	(Time Brint)		10h Maili	n - Andr	on (Straat			Wolowi		or Tour	State 7in	Codo	
Baltimore, Maryland 21215-0036	2 a a a		19a. Informant's Name/Relationship Betsey Hurwitz So		aughter		-				<i>l Route Numb</i> mber1a				C00 0)	
e,	1 and Health tern 27		20a. Mathod of Disposition			Place of Dispo					ate	_		City or To	wn, State	
10 I	permit. Pages 1 an Department of Heal Important: If Item 2 any injurpor other once.		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec		n State	tean Me			1	ar.	3, 200	4 ()1nev	, MD		
altir	permit. P Departme Importar any injur		21. Signature of Funeral Service Lic		puo						s-Rina					
Ö	De a File		Jant. 7	file		1	1800	New	Hamps	hire	Ave.	Silv	er S	pring	g, MD	20904
760,	Physician /Medical Examiner e parial-transit	cal Examiner	disease or condition resulting in death) Sequentially list conditions, fall, scaling or module cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due t	anced De o (or as a conse p Sis o (or as a conse o (or as a conse	quence of):										
.O. Box 68	the death certificate by the attending phy ached for use as the	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregree birth 2 Test gnant at time of known	tal death 3		pregnancy (specify)						te of delive	ory Day	Year
Vital Records, P.	uires that signed b	by	Part II. Other significant conditions	contributing to	death but not re	esulting in the u	ınderlyin	g cause give	en in Part I.						e cause of ably 4 [f death?]Unknown
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Re	The lav	mo									auto perf	ormed?		death?	npletion of 2 No	cause of
ital		0	25. Was case referred to medical						26. Place	of Death	(Check only			103	20140	
Į.	% 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 [Inpatient 2	☐ ER/Outpatie	nt 3	DOA Oth	er: 4 □ Nu	rsing Ho	ne 5□Res	idence	6 X Oth	er (Specify	Ass.	Living
on of	fe l		27. Manner of Death 1 ▼Natural 5 □ Pending 2 □ Accident investigat	(Me	te of Injury onth, Day Year)	28b. Time o	of M	28c. Injun Worl	yat k? Yes 2 □ h		28d. Describe	how inj	ury occur	red		
Division	7 7 7	Certification:	3 Suicide 6 Could not 4 Homicide determine	280. Pla	ce of Injury - At I Iding, etc. (Spec	home, farm, st	reet, fac	tory, office			28f. Location City or To			er or Rura	l Route Nu	ımber,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical (29a. Certifier 1 💢 Certifying (Check only one)	eminer: On the	he best of my kn basis of examin anner stated.	nowledge, deat nation and/or in	h occuri vestigat	ed at the timion, in my of	ne, date and pinion, deat	d place, a	and due to the ed at the time	cause(, date ar	s) and ma nd place,	anner as st and due to	ated. the cause	o(s)
	To th within To th comp	Me	29b. Signature and title of certifier					29c. Licenso					-		Day, Year)	
			15	the	- in	1,		D50	8/0			3/	2/20	U4		
	V		30. Name and address of person wh													
			Dr. Susan Abdo 50				Clar	ksvil	1e, M	D 21	029					
22.	Sta Regist		31. Date filed (Month, Day, Year)		Registrar's Sign	nature 6	Sp	outs	1							

State of Maryland / Department of Health and Mental Hygiene 2 1 1 1

				a.y.a.i.e.	Certifica	ate of	Death		Reg. No.	UH	03910		
	Dhuninin	1. Decedent's Name (First, Mi						2. Date of De Month		Year	3. Time of Death		
	Physiciar /Medica	1						March	4, 200)4	11:45P.M.		
	Examine	4e Fecility Neme (If not institute Montgomery Ho					4b. City, Town, or Rockvil		,	of Death GOME	ry		
	Funeral Director	5. Social Security Number 133–38–6012 Usuel Residence of Decedent	6. Sex 7. Ag	je (In yrs. lest bi 56	Yrs. If Un Month	der 1 Year ns Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, De April2	th by, Year) 12, 1947	9. Birthp Coun New	place (State or Foreign http) York		
	/land	10a. State 10b. Cou		10c. City, Tov						1	0d. Inside City Limits		
	a Man	Maryland Pri	nce George's	Belts	sville						1 ☐ Yes 2 XNo		
	th with the Me 23s or 28s-f s	10e. Street end Number 12911 Paca Dr	ive		10f.	Zip Code	20705		10g. Citizen of W		•		
020	72 hours after death with the Maryland natural; or items 23s or 28s-f show dical Examiner must be rotified at	3 □ Widowed 4 □ Divore	If Yes Give				lispenic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	14. Race Black Specify.	k, White,	ean Indian, etc. uite		
5-0	natural',	15. Dece (Specify only hig	dent's Education thest grede completed)	16e	Decedent's U (Give kind of	sual Occup work done	ation during most of wo	rking	16b. Kind of Bu	siness/Ind	dustry		
121		15. Dece (Specify only high			ife. DO NOT esearch				Academi	~			
9	医工事员 。			110	scar CII	DC1C.		ne (First, Middle,	Maiden Sumam				
/lan	should be marked o	Clifford Ly	le Hevenor				Margare	t Addis	on Moor	e			
lan	S D E E	19a. Informant's Name/Relation			_		and Number or Ru		-	-			
e, N	and Health	Karen Jeanett 20a. Method of Disposition	e Brown -Daugh		15 A. We of Disposition (/		ontgomer	y Avenue	Rockvil		Md. 20850		
Baltimore, Maryland 21215-0020	permit. Pages 1 Department of H Important: If Ite any injury or ot once.	1XXsurial 2 □ Cremation 4 □ Donation 5 □ Other		Vesta.	rry, crematory of L Hills	Memo:	i	c 3/13/2	004 Vest	al,	New York		
Bai	Departimon Importany in	21. Signature of Funeral Servi	ce Licensee	ss of Facility Borgward	Funera	1 Home,	P.A.						
-		232 Part Fotor the dispass	or complications that cause	d. Belts	ville, M	aryl	and 20705						
1	Physician	23a. Part1. Enter the disease shock, or heart failure. I	ist only one cause on each li	ne.	THOU SHILES LISTS	loue or uyii	ig, soon as cardian	or respiratory a	11631,	1	Approximate Interval Between Onset and Death		
1	/Medical	Immediate Ceuse (Final disease or condition	Metasta	atic Car	cinoma						5 years		
	Examiner	resulting in death)	a	Due to (or as a	consequence of	of):				1	2		
	Day is		Breast	Cancer							15 years		
60,	iceta be executed physician end is tha bunel-trensit		c	Due to (or as a	consequence o	of):			-				
68760,	rificeta be ng physicia es tha bu	resulting in death) Last		Due to (or as a	consequence o	f):				1			
Вох	eth certi ettending for use		d						71.27	1			
	at the death ce d by the ettendi etached for use	Part II. Other significent cond	itions contributing to death b	ut not resulting i	in the underlyin	g cause giv	ren in Part I.	23b. Did 1	tobacco use con	tribute to	the cause of death?		
s, P.O	es that the igned by the be detach		Thyroiditis					10	Yes 2⊠ No	3 ☐ Prob	pably 4 Unknown		
of Vital Records,	aw requii								an autopsy rmed?	ava	ere autopsy findings ailable prior to mpletion of cause death?		
<u>ه</u>		8						404	fes 2∑Nc	1 🗆	Yes 2□ No		
Vit _s	Physician: The this certificate ral director, per To Be Co.	examiner?	Hospital:			DOA Oth	or:	ath (Check only o					
on of	tending Physic leath. tor: After this of the funeral directors.				utpatient 3 Time of Injury	28c. Injur Wor	4LI Nuising F		dence 6 XOthe now injury occurre) HOSPICE		
Division	is after death. In Director: After the din by the funers	2 Accident Inve	stigation Ild not be armined 28e. Plece of Inj building, et	ury - At home, fa c. (Specify)		_	res ZUNO	28f. Location (8 City or Tox	Street and Numbe vn, State)	er or Rura	l Route Number,		
	To the Hospital or Atte within 24 hours after de To the Funeral Directo complataly filled in by the Maddical Certific		ying Physician: To the best al Examiner: On the basis of end manner sta	f examination ar	e, death occurre nd/or investigati	ed at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and mar date and place, a	inner as stated. and due to the cause(s)			
	within To the comp	29b. Signature end title of cert	ifier P >	2 -	2	29c. Licens			-	ned (Month, Dey, Yeer)			
	20	5.	V. Lib	re a	CD	D094	± /U		March 5	, 200) 4		
		30. Name end address of pers Eugene P. Lib	re, M.D. 10400			venue	e Kensing	ton, Mar	yland 20	0895			
	State	31. Dete filed (Month, Day, Ye MAR)		er's Signature	6 1	200 3/2	1						

Henrisson

State of Maryland / Department of Health and Mental Hygiene 2004 0961

					Certificate of	Death	Reg	. No.	1 09611
	Dhusisis		1. Decedent's Name (First, Middle, Lest)			. Dete of Deeth Month	Dey Year	3. Time of Death
-	Physicia /Medic		CLARA E. 1	HEBRON			norch	9 2004	615 AN
	Examin		4e Facility Name (If not institution, give Shady Grove Ad	·		4b. Cify, Town, or Loca Rockvi		4c. County of Deeth MONTO	GOMERY
	Funeral Director		5. Social Security Number 2.20-3.2-6.5.8.7 Cusuel Residence of Decedent	7. Age (In yrs. last b	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Dey, Yo eb. 4, 1	9. Birth Cou 918 Ma	nplace (State or Foreign untry) arvland
3	A		10a. State 10b. County	10c. City, Tov	vn or Location			İ	10d. Inside City Limits
Man	Mary Mary	ģ	MD Montgo	mery	Dickerson				1 X Yes 2 □ No
di di	23a or 28	al Director	10e. Street and Number 21201 Big Wood	ds Road	10f. Zip Code	0842	10g.	. Citizen of What Cou	intry?
21215-0020	in ratious ellel deam with the maryar "natural", or Nema 23a or 28a-1 show edical Examiner must be recified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🎗 ₩idowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hilf Yes, specify Cub	dispanic Origin? (Specif an, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ameri Black, White Specify: Black	, etc.
5-0		eted	15. Decedent's Edu (Specify only highest gred		Decedent's Usual Occup	pation during most of working	168	b. Kind of Business/Ir	ndustry
2	9 5	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired House			Home	
d 2	Hygie T, er	ပ္	7th 17. Father's Name (First, Middle, Last)		House	18. Mother's Name (F	irst Middle Mai		
ian	ked o	To Be	Albert Thomp	son			er But		
, Maryiand	elth and N 27 is mar or traumal		19a. Informant's Name/Relationship (Ty Florence Rando	pe, Print) 1ph (Daughter	o. Mailing Address <i>(Street</i>) 21201 B	and Number or Rurel F Big Wood F	Route Number, C. Rd., Di	ify or Town, State, Zi Ckerson	, MD 20842
Baltimore,	Deperment of Heelth and Mente Hygier Important: If Item 27 is marked other the any injury or other traumatic event, in once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	of Disposition (Name of ary, crematory or other plea en Church	CΘ)		. Location - City or T Martinsk	
Balt	Deperture Supports any Injure once.		21. Signature of Euneral Service License	nowden		oss of Facility SNOW Wash. St.,			
,	IET		23a. Pert1. Enter the disease, or compli shock, or heart ailure. List only or	ications that caused the death. Do ne cause on each line.	not enter the mode of dyin	ng, such es cardiac or re	espiratory arrest,	1	Approximate Interval Between
	hysician /Medical		Immediate Cause (Final						Onset and Death
	xaminer		disease or condition resulting in death)	sepsis					days
		Je.		Due to (or as a	consequence of):			1	
7 LL	g physician and as the burial-transit	edical Examiner	Sequentially list conditions,	Due to (or as a	consequence of).				
9	ician burial	四田	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury),					
x 68760	phys s the	edic	that initiated events resulting in death) Last	Due to (or as a	consequence of):				
	a di	₹	L d	1					
æ Zå	e atte	Sicia	Pert II. Other significent conditions con-	tributing to death but not resulting i	n the underlying cause giv	en in Pert I.	23b. Did tobac	co use contribute t	o the cause of death?
	ned by the datache	y Phy	bowel obs					1	ebably 4 ☐ Unknown
	has been signed by the attendin	Completed by Physician					24a. Was an au performed	l? av	fere autopsy findings vailable prior to empletion of cause death?
x < ≥	ata h	50					1∐ Yes	25HU 1[□Yes ZÓNo
2 4 §	certificata irector, per	a	25. Was case referred to medical examiner?	lessitely - 1	Tou.	26. Place of Death (C	heck only one)		
	this or	2	1 Yes No	lospital: 2 ER/Ou		4 LI Nursing Home		6 □Other (Specif	'y)
VISION Paragonal Area and and and and and and and and and an	efter deeth. Director: After thi d in by the funeral	cation	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)	njury Worl M 1 □	Yes 2□No	. Describe how in		
NIO CONTROL	within 24 hours efter deeth. To the Funeral Director: After this certificata has complataly filled in by the funeral director, pege 2	Medical Certification:	4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)			City or Town, St	_	
- Hoes	24 hours Funeral lataly filled	dica	29a. Certifier (Check only one) Certifying Physical Examin	iclen: To the best of my knowledge ler: On the basis of examination an and manner stated.	e, death occurred et the time d/or investigation, in my op	ne, date end plece, and pinion, death occurred a	due to the cause at the time, date a	e(s) end menner as s and place, and due to	teted. the cause(s)
N E	within 2 To the compla	¥ e	29b. Signature end title of certifier		29c. License	e number	29d.	Date signed (Month,	Dey, Year)
	10		> Flician,	Mistry Mr.	D 5	19738	M	orch 9,2	004
	V -		30. Name end eddress of person who cor Alicia Mistry	mpleted cause of death (Item 23e) 9901 Medica	(Type, Print)	Prive R	ockvill	e, MD 2	0850
k i	State Registra	_	31. Date filed (Month, Day, Yeer) MAR 1 1 20	32. Registrar's Signature	& Some	2			

			_ State	State of Maryland	/ Depa	artment o			ental Hygie	ene 2	004	091	512
	Physici /Medic		1. Decedent's Name (First, Middle, Last) MELISA A.						2. Date of Death Month MARCH	Day 5 , 2	2004	3. Time of 2:25	
	Examin		4a. Facility Name (If not institution, give st 13920 Castle E		birthday)		n, or Location of Per Spi	ring		MON	NTGOM 9. Birtho		r Foreian
1	Funeral Director		0.000	M 25€ 42	Yrs.	Months Da		Min.	8. Date of Birth (Month, Day,) Jan • 10 ,	(°1′962		lece (State or itry) rylan	
	e Marylan te-f ehow	ctor	MD Montgom	nery 10c. City, To		ver Sg						0d. Inside Cit	
	23a or 28	rai Dire	13920 Castle B				20904			τ	J.S.A	•	
036	urs after des al', or Items Examinar m	by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:			of Hispanic Orig Cuban, Mexican No Specify:	gin? (Spec i, Puerto F	cify Yes or No- lican, etc.)	В	ace - Americ lack, White, cify: B1	etc.	
Maryland 21215-0036	within 72 ho ene. than "natur to Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give life. L	dent's Usual Ockind of work do DO NOT use re	one during most tired)	t of workin	g		Business/Ind	lustry	
yland 2	uid be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) Larry Willia					Car	(First, Middle, Ma Olyn Ha	11			
, Mar	and 2 sho eaith and n 27 is mu		19a. Informant's Name/Relationship (<i>Typ</i> Carolyn William	s (Mother)	608	Rosem	ere Av	ле.,	Silver	Spr	ing,	MD 2	0904
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural, or Items 23a or 28a-f show any injury or other traumatic event, Its Medical Examinar must be notified at any injury or other traumatic event, Its Medical Examinar must be notified at once.		20a. Method of Disposition ↑ ChBurial 2 □ Cremation 3 □ Re ↑ 4 □ Donation 5 □ Other (Specify) 21. Sgnatum I neral Service Licensee	Broc	oke (Cem 3	3/12, , SN	/04 I OWDEN F	ayto	CAL H	lle, I	P.A.
	Fnysician /Medical Examiner		23a. Part 1. Enter the disease, or complice shock, or heard failure. List only one Immediate Cause Final disease or condition resulting in death) Sequentially list conditions.	ations that caused the death. Do cause on each line. AIDS (Acqui Due to (or as a consequence HIV Wasting Due to (or as a consequence)	red ce of):	er the mode of	dying, such as a	cardiac or	respiratory arres	t,		Approximate Interval Betwoonset and D	e ween Death YS
8760,	cate be executed obysicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	HIV Infecti	on						0.3	3 Yean	rs
.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy for the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	ath 3	Ectopic pregna Other (specify					Date of delive	-	ear/
Q	quires that n signed by uld be deta	by	Part II. Other significant conditions cont Cerebral Pal	-	ig in the u	nderlying cause	given in Part I.		23e. Did toba 1 ☐ Yes			ne cause of de ably 4 □U	
II Reco	The law requirestee that the same that the same that the same same that the same that	Completed						_	24a. Was an autopsy performs	1		psy findings a npletion of ca 2 No	
of Vita	Physician: rrthis certific sral director.	To Be	25. Was case referred to medical examiner? 1 Yes 25 No 27. Manner of Death	ospital: 1 Inpatient 2 EP/ 28a. Date of Injury 28i	b. Time of	28c. I	Other: 4 Nui	rsing Hom	(Check only one) ne 5 Resident 8d. Describe how			"	
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1XXatural 5 Pending envestigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day Year) 28e. Place of Injury · At home building, etc. (Specify)	Injury , farm, str	М	Work? 1 □ Yes 2 □ N ice		8f. Location (Stre City or Town,		mber or Rura.	l Route Numi	ber,
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical Ce		cian: To the best of my knowled er: On the basis of examination and manner stated.)
	To the To the compile	Me	29b. Signature and title of certifier May	el Smo		1	cense number	78		•	ned (Month, I	1.7	
	V		30. Name and address of per who con Margaret Chang				Lane,	, Si	lver Sp	ring	, MD	2091	0
1	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2004	32. Registrar's Signature	19	Spore	Kal						

State of Maryland / Department of Health and Mental Hygiene For State Registrar 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** P^{M} 4:30 DOROTHY REBECCA HAYDON March 4, 2004 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner St. Mary's 49993 Airedale Road Ridge If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplac Country, March 30,1910 Wash. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TF Yrs. 93 D.C. Director 220-32-6351 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at St. Mary's MD Ridge 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 49993 Airdale Road 20680 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. snt: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married 10. Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ 3 ⊠ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Boswell Elsie Warner 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 49993 Airedale Road, Ridge, MD 20680 Charles Edward Haydon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If any injury or once. Cedar Hill Cemetery 03/08/2004 Suitland, MD □ Donation 5 □ Other (Specify) 21. Signature of Furieral Service Licenses 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Herrsylvania Avenue, Suitland, MD 20746 Approximate Inter al Betweer On et and Deat 23. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cordiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nmediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a-conse Division of Vital Records, P.O. Box 68760, lan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Physicia 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 212No 3 Probably 4 Unknown 1 Tyes Completed Deen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 Yes 212 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 2 3□ DQA this funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, MD 2403/Three Notch Road, Hollywood, MD 20636 31. Date filed (Month, Day, Year) MAR 0 8 2004 2. Registrar's Signature State Registrar

ORIGINAL

•		1	_ State	State of Maryland		rtment of H			ene a. No. 2004	09611
Phy:	sicia	-	n. Decedent's Name (First, Middle, Last) Marvin Arthur Ho	1den		outo or i		2. Date of Death Month		3. Time of Death
	edica mine		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or		March	4c. County of Deeth	11100
Fune	ral	-	Washington County 5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	Hagerst If Under 1 Year Months Days			Washing 9. Birthy	CON place (State or Foreign
Direct	tor		Usual Residence of Decedent	^{M 2□F} 79	Yrs.			April 18	, 1924 Blo	cker, OK
Marytan I-f ehow		Į.	PA Frank	lin 10c. City, To	aynes				·	10d. Inside City Limits 1 XYes 2 No
with the		Direc	10e. Street and Number 38 Philadelphia	Ave		10f. Zip Code 1726	8	10	g. Citizen of What Coul	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: It less 25 it marked other than "netural", or items 23s or 28s-1 show any injury or other transmission on the property.		by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1 Types 2 No If Yes, Give 1946				Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	can Indian,
ithin 72 houle.	ŀ	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	ent's Usual Occupa kind of work done of OO NOT use retired	during most of wo	rking	6b. Kind of Business/In	dustry
ld be filed wi		To Be Con	3 17. Father's Name (First, Middle, Last) Benjamin Lee Hol	den	Tool	. maker		me (First, Middle, Me 7 Pierce	Machine sh aiden Sumame)	ор
and 2 shot eaith and h			19a. Informant's Name/Relationship <i>(Typ</i> Norma D. Holden	e, Print) 1 spouse					city or Town, State, Ziporo, PA 172	
nit. Pages 1 artment of He ortant: If item			20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☑ Re 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	moval from State Fair	field		em. Mar.	24, 2004	- Fairfield	
	Buce		Deanette M	Tel melie	1	00 S Broa	d ST Way	mesboro,	PA 17268	- Home, Inc
Physici /Medio Examir	al		23a. Part1. E ter the disease, or complic shock, b heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Decays on each line. Due to (or as a consequence)	ple	or the mode of dying	g, such as cardia	c or respiratory arres	st.	Approximate Interval Between Onset and Death
cate be executed shysician and the burial-transit		lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
The law requires that the death certificate be executed the has been signed by the attending physician and hand 2 should he detached for use as the burital-liancel.		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death		Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
quires that in signed b	3 .	à	Part II. Other significant conditions cont	ributing to death but not resultin	g in the un	derlying cause give	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to the	ne cause of death?
	4	Completed	Chrone Uh	Structure Len Juses	len	y dezi	esse	24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
Physician: The Physician: The Italian The Italian Physician	lo Be	25. Was case referred to medical examiner? 1 🗆 Yes 2 🗖 No	Ospital: 1 Thipatient 2 ER/	Outpatient	3□ DOA Othe	N.C.	ath (Check only one)	ce 6 □Other (Specif	v)	
a de de de			27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	o. Time of Injury	28c. Injury Work M 1 🗆		28d. Describe how		
To the Hospital or Attending Within 24 hours after death. To the Funeral Director: After completely filled in by the funeral principle.		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town,	,	
To the Hospital or within 24 hours after To the Funeral Discontinuous filled in		Medical	one) 2 Medical Examin	cien: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or inv	estigation, in my op	oinion, death occi	urred at the time, date	e and place, and due to	the cause(s)
To	3	4	29b. Signature and title of certifier	1 Les	m	29c. License	3625	290	1. Date signed (Month,	L Zwy
S			Fredera Lt 1	noleted cause of death (Item 23	1111	o med	red C	Empus	Red 16	-gerstum
Door	Stat		31. Date filed (Month, Day, Year)	32. Registrar's Signature	20	1		•		my

State of Maryland / Department of Health and Mental Hygiene 2004 09615 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 20, Day 004 **Physician** 1:50 PM M Joseph William Hewitt /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 2830 Kaetzel Road Knoxville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth American State or Foreign April 4, 1950 Mary Tand 5. Social Security Number 219–46–2952 6. Sex 1∑ M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days Hours Min Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28s-f show other traumetic event, the Mcdical Examinar must be notified at 1 Yes 2 No Washington Knoxville Maryland Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21758 U.S.A. 2830 Kaetzel Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Xi Yes 2 1 No. 1968–1972

If Yes, Give 1968–1972 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritat Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Decedent's Usuat Occupation
(Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiene. Coltege (1-4or 5+) Loader Operator Stone Quarry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Heant: If item 27 is marked off jury or other traumatic even Rosemary Woolever Willis N. Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 2830 Kaetzel Road, Knoxville, Maryland 21758 Clariss M. Hewitt, wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Resthaven Memorial Gardens March 23, 2014 Frederick, Maryland 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Reeney and Bastord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician y cai resutting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) P.O. Box 6876 Physician/Medical Attending Physician: The law requires that the death certificate be as the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ pe 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2 2 No 25. Was case referred to medical 26. Place of Death | Check only one Cther: 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 6 To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 22, 2004 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) Elhamy Frederick Eskander MI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 6 2004 Consess.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yoeun /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctors Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Director 578-06-4834 83 5,1920 CAMBODIA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f shov nutilist at 1X Yes 2 □ No Directo MD. PRINCE GEORGES NEW CARROLLTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural, or items 23s or uxor other treumatic event. The Modical Examination with the 8604 POWHATAN ST. 20784 CAMBODIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced ASIAN 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DEFENSEMAN CAMBODIA ARM SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be KIING UM TEP TOUCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) POWHATAN ST., NEW CARROLLTON, MD. 20784 NISAY SAY/GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injuryer once. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 3-9-2004 RIVERDALE, MD. permit. 21. Signature of Funeral Service Jugensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EREBROVASCYLAR ACCIDENT **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of Examine Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physiclan/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a certificate has been signed irector, page 2 should be de Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tyes 2 PNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes 2 100 director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA After this the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 24 hours after death. • Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined within 24 hours after dea To the Funerel Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To tha I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7305 Hanover Grenbeit, Mary land Caul Donald 6ugs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 9 2004 Registrar

			For State Registrar	State of Maryland / [Department of Heal Certificate of Deal		ntal Hygiene Reg. No	2001	09617
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Samuel R.	IKER			Date of Death Month Day arch 10,2		3. Time of Death 12:26A M
	Examin		4a. Facility Name (If not institution, give s 5214 Norway Drive		4b. City, Town, or Loca Chevy	Chase		. County of Death Montgome	ry
	Funeral Director		5. Social Security Number 322–24–6065 6. Sex 1 Security Number 1 S	72			Date of Birth (Month, Day, Year) oril 23,19		place (State or Foreign ntry) inois
	Maryland -f show	tor	10a. State MD 10b. County Montgomer	y 10c. City, Tow Chevy					10d. Inside City Limits 1 ∑Yes 2 □ No
	death with the Maryland ms 23a or 28e-f show (must be notified at	al Director	10e. Street and Number 5214 Norway Drive	:	10f. Zip Code 20815		10g. Cit	izen of What Cou	
-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. is marked other than "natural", or items 23a or 28e-1 show eumatic event, It a Medical Examinational be notified at	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No 1f Yes, Give Year or Dates: unknown	13. Was Decedent of Hispan If Yes, specify Cuban, Me 1 Yes 2 No Sp	ic Origin? (Specify exican, Puerto Ric ecity:	an, etc.)	14. Race - Americ Black, White, Specify: Wh:	ite
Maryland 21215-0036	d within 72 jiene. r than "nai	Completed	(Specify only highest grade	College (1.4or 5+)	(Give kind of work done during life. DO NOT use retired) ournalist	nost of working		ind of Business/In ne Magaz:	
/land :	should be filed nd Mental Hygi t marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Charles I	ker	18. !	Mother's Name (F Sarah	irst, Middle, Maiden Weir	Sumame) ncord	
	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic and once.		19a. Informant's Name/Relationship (Ty), Jean I ker / s_p	ouse 52	o. Mailing Address (Street and Norway Dr.,	, Chevy C	Chase, MD		o Code)
Baltimore,	Pages 1 ment of Hi ent: If iter		20a. Method of Disposition 1 ∑5uriai 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Mt . Le	f Disposition (Name of ry, crematory or other place) ebanon Cemetery	March l	.1 Ade1	Lphi, Mai	
Ball	permit. Departr Importe any inji	V 00	21. Signature of Funeral Service Licepter	Bigler	22. Name and Address of 1	St., N.W.	, Washing		C. 20012
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Adenocarcino Due to lor as a consequence	oma of):	ch as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death 4 year
8760,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):				
.O. Box 6	death certif e attending od for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delive Month	ery Day Year
rds, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but not resulting in	n the underlying cause given in l	Part I.	23e. Did tobacco u	_	he cause of death? pably 4 Dunknown
al Reco	The law ate has b page 2 sl	Completed					24a. Was an autopsy performed? 1 □ Yes 2 ☒No	prior to co	opsy findings available impletion of cause of
Division of Vital Records,	Attending Physicien: The Indeath. ector: After this certificate hate the funeral director, page	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Dthor	28d	heck only one) 5 Residence Describe how injur		у)
Divis	al or Attendes s after death of Director: ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory, office	28f.	Location (Street an City or Town, State		nl Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical (29a. Certifier 1 X Certifying Physical (Check only one) 2 Medical Exemination	ician: To the best of my knowledge er: On the basis of examination an and manner stated.	nd/or investigation, in my opinion	n, death occurred a	due to the cause(s) It the time, date and	and manner as si place, and due to	tated. o the cause(s)
į	To the L	2	29b. Signature and title of certifier	Huseun	DC 5496		March	,	
	*		30. Name and address of person who co Michael A. Newman		(Type Print) •, N.W., Washi	ngton, D	.c. 20006		
	Sta Registi		31. Date filed (Month, Day, Year) MAR 11 200	32. Registrar's Signature	5 Sporter				

			For State Registrar	State of Marylan	d / Depa	artment of F	lealth a	nd Mental I	Hygien Reg. N	e 200	4 09618
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last) Jefferson Davi Aa. Facility Name (If not institution, give s Doctors Communi	d Jenrette,	Sr.	4b. City, Town, o		2. Date of Month	h 8	year 2007 c. County of Dea	th
(II) (II)	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of (Month) March			thplace (State or Foreign sunty)
	Maryland a-f show iffed at	ctor	Maryland Prince Ge		y, Town or Lo Foresty						10d. Inside City Limits 12€ Yes 2 □ No
	th with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 6323 Sunvalley Tr.			10f. Zip Code 2074	7		-	itizen of What Co	•
960	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show Itsal Examinat must be invitted at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No		in? (Specify Yes or Puerto Rican, etc.	No-	14. Race - Ame Black, Whit Specify:	
1215-0	within 72 he ene. than "natu he Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th	cation e completed) College (1-4or 5+)	life.	dent's Usual Occup kind of work done of DO NOT use retired og Cutter	ation during most d)	of working		Kind of Business Private	/Industry
Maryland 21215-0036	12 should be filed within " h and Mental Hygiene. F is markad other than " traumatic avent, the Me.	To Be Co	17. Father's Name (First, Middle, Last) Henry Dasha Jenre				Susa	's Name (First, Mid in Jane Ro	dle, Maide	n Sumame)	
Baltimore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than 'natural', or Itams 23a or 28a-f show any injury or other traumatic avent, the Madical Examinar must be inclined at once.		19a. Informant's Name/Relationship (Ty. Betty Hardy / Dau 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☑R 1 □ Donation 5 □ Other (Specify)	ghter 20b. F	6323	Sunvalle sition (Name of matory or other place	y Tr.	Forestvi Date 5/14/2004	11e, 1	Md. 207 Location - City or	47 Town, State
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al Rec	The la ate has page 2	Comple						p	Masan utopsy erformed? s 2 ☑ No	prior to death?	topsy findings available completion of cause of
V.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		- Oth		of Death (Check or			
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Divi	ital or Attendir rs after death. ral Diractor: Al	Certifi	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str	reet, factory, office			n (Street a Town, Stat		iral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	Medical	(Check only 2 Medical Exemit	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deatl ition and/or in	vestigation, in my o	pinion, deat	place, and due to to occurred at the tin	ne, date an	d place, and due	to the cause(s)
	To To con	Σ	29b. Signature and title of certifier Shurf Hun	m, MD		P S	508	52	MA	RC(1 - 9	
R	(8)		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type,	Print) SHER	ANUI	ASSANIAM.	02:	706	XXXXX
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 1 2004	2. Registrar's Signa	Space	W					

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Junethy Jefferson D

1-	For State Registrar

		_ 1	For State State Registrar	e of Maryland / D	epart Certi	tment of He	ealth and M Death		ene 2 { g. No.	04	09619
			. Decedent's Neme (First, Middle, Last)					2. Date of Death Month	Day	Year	3. Time of Death
	ysicia Medica	al _	Vattel					March 8	, 2004	45 11	4:40 P. M
Ex	camine	er	a. Facility Name (If not institution, give street and Springbrook Adventis	t Nursing	4		Location of Death		4c. County	tgome	
E. 100	neral		and Rehabilitation Social Security Number 6. Sex	7. Age (In yrs. last birt		Silver	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birth	plece (State or Foreign
	ctor		578-12-2201 ¹₺м 2□	F 90	Yrs.	Months Days	Hours Min.	June 23	,1913		rginia
and *		-	Jsuel Residence of Decedent 10a, State 10b, County	10c. City, Town	n or Local	tion					10d. Inside City Limits
Maryli -1 •ho	a pail	ţ	Maryland Montgomery	Si	lver	Spring					1X Yes 2 No
h the	nati	0 L	10e. Street and Number 12325 New H			10f. Zip Code		10	g. Citizen of	What Cou	intry?
23a C	dia	a	Springbrook Adventist	Nursing Home			904		United		
parifilliorie; Mai yidailio 21213-0000 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.	amioirm	by Funeral	1 Never Married 2 Married 1 1	Decedent Ever in U.S. d Forces? fes 2 1 No s, Give or Dates:	1	is Decedent of His es, specify Cubar Yes 2 No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ck, White, y : $\mathbf{B1}$	
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shoul and Me	umati	۲	19a Informant's Name/Relationship (Type, Print The Ima Rust Jackson (W	ife) & 19b	. Mailing	Addrass (Street a	and Number or Rura	al Route Number,	City or Town	, State, Zi	ip Code)
ond 2 satth a	er tre		Portia Maria Jackson(d	aughter) 64							n,D.C.20012
Deficiency of the popular of the properties of t	ury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal 1 4 □ Donation 5 □ Other (Specify)	rom State	ry, crema	tory or other place	March Lothian	14,2004	Coc. Location Loth emeter	ian,	Maryland
permit. Departr	eny inj		21. Signature of Funeral Service Licenses	Ellom	²² R 6	Name and Addres N. Hor OO Kenne	rton Compa edy Street	any Mort	icians ashing	, Ind	c. D.C.20011
ė,			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the deeth. Do no each line.		1 .	g, such as cardiac o	or respiratory arre	st,		Approximate Interval Between Onset and Death
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9 a	nas 19 2	Completed	remember ce	Py				24a. Was a autops perforn	ned?	prior to a death?	opsy findings available ompletion of cause of
6	certificate rector, pag	e Co	25. Was case referred to medical				26. Place of Deatl		a)	1 🗆 Yes	20 No
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Hospital or Attending Hospital or Attending A hours after death.	• Funeral Dir fetely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physician: 2 Medical Examiner: On and								
To the within 2	To the	Me	29b. Signature and title of certifier	19,8-1		29c. License	e number	2	9d. Date sign		, Day, Year) , 2004
0 /	5		30. Name and address of person who completed	cause of death /Item 22a	(Tyne P	rint)	0 -1 1		11GE CII	10 9	20910
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pe:	r R. Ja			State of Maryland						21 00-
			State Registrar	·	Cer	tificate of	Death		Reg. No. 20(J4 U962N
			1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physici /Medic		Jasper Ricard	o Jackson				March		355 a M
)	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, o	Location of Death		4c. County of [
			Balt/Wash Pkwy at	Rt 197		Laure	1		Prince	Georges
	Funeral		5. Social Security Number 6. Sex		st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	th 9.	Birthplace (State or Foreign
	Director		578-04-3487	^{M 2□ F} 38	Yrs.	Months Days	Hours Min.	8. Date of Bi	65" W	ash.,D.C.
	ъ		Usual Residence of Decedent				-			
	how		10a. State 10b. County	10c. City,	, Town or Lo	cation				10d. Inside City Limits
	a-f s	Ş	MD. P.G.	Fo	rt Wa	shingto	n			1 ☐ Yes 2X No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	within 72 hours after death with the Maryland ane. than 'natural', or items 23a or 28a-f show ta Madical Examina must be notified at		6707 Janet Lane			20744	ļ		United :	States
	deat	Funeral	11. Marital Status	2. Was Decedent Ever in U.S	i. 13. \	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No	- 14. Race - /	American Indian,
ယ	or its	II.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ∑No	1			Hican, etc.)	Black, V	Vhite, etc.
ğ	urs a	Ď	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 2 th No	Specify:		Specify:	Black
21215-0036	2 ho	Completed by	15. Decedent's Educ		16a. Deced	lent's Usual Occup	ation during most of work	li in a	16b. Kind of Busin	ess/Industry
2	Pin 7	ed d	(Specify only highest grade	College (1-4or 5+)	life. L	DO NOT use retired	1)	ang		
2	d wit)OII	Elementary/Secondary (0-12)		Po1	ice Off	icer		DC. Pol:	ice Dept.
g	il Hygir other	0	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Sumame)	
<u>a</u>	ild by Fenta Ked ic e	To B	Johnnie Jack	son			Mary	Mi11e	e r	
Maryland	should be and Mental I marked o		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	g Address (Street			er, City or Town, Sta	te, Zip Code)
ž	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importance of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-7 show any higher or other traumatic event, the Medical Examinal must be notified at any higher.		Sandra Jackson/	wife	6707	Janet	Lane Fo	rt Was	sh.,MD.	20744
Baltimore,	tam tam othe		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place		Date	20c. Location - City	or Town, State
2	Pages nent of int: If it iry or o		1 Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	Billoval Itolii State	_	natory or other plac .ncoln	l l	1 /04	Dwankers	ad MD
₫	it. Partme		21. Signature of Funeral Service License			. Name and Addre		1/04	Brentwoo	
Ba	permit. Departr Importa any inju		NIM JULIA	11 MAN1170				al Hon	420 H	Street NE., DC.20002
			23a. Part1. Enter the disease, or complic	at look that caused the death						Approximate
5			shock, or heart failure. List only on	e cause on each line.	. Do not ont	1	g, such as cardiac	or respiratory a	1163(,	Interval Between Onset and Death
p	Physician		Immediate Cause (Final disease or condition resulting in death)	Multiple	2 in	rusie.	5			
0	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	5				
	Examine	_	Sequentially list conditions, b							
	D H	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury	Due to (or as a conseque	ence of):					
	and tran	ram	that initiated events resulting in death) Last							
,092	ate be executed hysician and the burial-transit	<u> </u>	resulting in deathy cast	Due to (or as a consequent	ence of):					
376	ate b hysic he b	Ical	d							
89	death certificate b e attending physic d for use as the b	Med	IF FEMALE:							
Вох	th ce tendi	an/l	23b. Was decedent pregnant 23	3c. If yes, outcome of pregnant 1 Live birth 2 Fetal		Ectopic pregnancy	,		23d. Date of	,
	deat ne at ad fo	12	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of dea 9 Unknown		Other (specify)			Month	Day Year
P.0	that the de ed by the detached	Physician/M	9 Unknown	3LI OTIKITOWIT						
	law requires that as been signed b 2 should be dete	by F	Part II. Other significant conditions con	tributing to death but not resul	lting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco use contribut	te to the cause of death?
Ď	w require been sig should t	ed						1 🗆	Yes 2ŪKNo 3⊡	Probably 4 Unknown
00	s been s been s shouk	ompleted						24a. Was	an 24b. Were	autopsy findings available
Re	0 2 0	E							rmed? deat	to completion of cause of
Vital Records,	ician: Th certificate rector, pag	Ö	25. Was case referred to medical				00 Diagram		2 No 1	Tes 2□No
5	Physician: this certific ral director,	0 0	examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	• 3C DOA Oth	er:			
of		H ::	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injur	y at	ome 5 ☐ Resi 28d. Describe	how injury occurred	Specify) at scene
on	ding l h. After funer	ţ.	1 ☐Natural 5 ☐ Pending 2 ☐Accident investigation	(Month, Day Year)	2 Injury	Wor	k? Yes 2 XVo	Drive	r in M	OFOR
8	Attending r death.	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ne farm str		7	28f Location (Street and Number of	r Rur I Route Numb r,
Division	or Attenuater deatl	Certification;	4 Homicide determined	building, etc. (Specify)	· -			Q Gity or To	wn, State)	Noton Posting
_	Hospital		29a. Certifier 1☐ Certifying Phys	ician: To the best of my know	dodgo dooth	~		St KE	U362 197	rairel MD
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only Medical Examin	er: On the basis of examination and manner stated.	on and/or inv	estigalin, in my o	pinion, death occur	red at the time,	date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mariner stated.		29c. Licens	e number		29d. Date signed (M	onth Day Yearl
	7 with		1	· 110	0 -	OCME			March 7 2	
0	(2)	. 0	19th W	mr 106	Lore					
_	101		30 Name and address of person who con	mpleted cause of death (Item	23а) (Туре.	2 111 Pe	enn Stree	t, Balt	imore, Mai	cyland 21201
			31. Date filed (Month, Day, Year)	32. Registrar's Signatu	JM				•	_
	Sta Registi		MAR 1 2 2004	See L. Hegistrar's Signatu	breek	2				
100			IMALI T W TATE	AND THE PERSON NAMED IN	14	-				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARCH 2004 HARVEY 6:26 JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CLINTON PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL 8. Date of Birth (Month, Day, Year) 9 FEB 20,1938 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Days **Funeral** Hours 1**X**□M 2□F 66 WASH.DC Director 577-50-0595 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County in than "natural", or iteme 23e or 28e-f show the Modical Examiner must be notified at 1 TYes 2 □ No CLINTON Director PRINCE GEORGES MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20735 U.S.A. 9505 PISCATAWAY ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) CHEF permit. Pages 1 end 2 should be filed wind Department of Health and Mental Hygien Importent: If Item 27 is marked other the any injury or other traumatic event, ITEM 2006. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) UNKNOWN JOHNSON GIRLENE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3005 BLADENSBURG RD., NE WASH.DC 20018 TROYCE JOHNSON -DAUGHTER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State GLENWOOD CEMETERY 3-13-2004 WASHINGTON, DC • 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 21. Signature of Funeral Service Licensee 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): YPOXER /Medical **Examiner** NEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Division of Vital Records, P.O. 9 Unknown iis certificate has been signed by director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 ☐ Yes 2 😿 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospitel or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely within 2. To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D50862 Hann, MARCH, 9, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif Hassan - 9831 Greenbelt Road, Lanham, Maryland 20706 31. Date filed (Month, Day, Year) MAR 1 2 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09622 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician HERBERT **JAMES** MARCH 2004 9:10 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Casey House Rockville MONTGOMERY **Funeral**

Director

Baltimore, Maryland 21215-0020

/Medical

Division of Vital Records, P.O. Box 68760,

Herbert

Physician Examiner

	5. Social Security No	umber (S. Sex	7. Age (In yrs.	last birthday)	If Under	er 1 Year Days	Hours Hours	24 Hrs. Min.	8. Date of Bi (Month, D	irth le <i>v. Yeer)</i>		9. Birth	place (State intry)	or Foreign
	229-34-4	018	1 ∑ M 2□ F	71	Yrs.	, wonth				Sept.				rgin	ia
	Usual Residence of	Decedent													
	10a. State	10b. County		10c. Ci	ity, Town or Lo	ocation								10d. Inside	City Limits
to	MD	Princ	ce Geor	ges	H	yatı	tsvi	lle						1 ₹ Ye	s 2□No
Fe	10e. Street and Num	ber				10f. Z	ip Code				10g. Cit	izen of W	/hat Cou	untry?	
<u>a</u>	8235	New I	lampshi	re Ave	•		2	0783			1	U.S.	Α.		
e l	11. Marital Status		12. Was De	cedent Ever in L	J,S. 13.	Was Dec	edent of H	lispanic Or	igin? (Spe	ecify Yes or N Rican, etc.)	0-		e - Amer	ican Indian,	
	1 🗆 Never Marrie			200 No		1 ☐ Yes		Specify:		, tiouri, 010.				Lack	
g D	3 Widowed	4 Divorced	Year or												
To Be Completed by Funeral Director	(Speci		grede completed		16a. Dece (Give	dent's Usi kind of w DO NOT	ual Occup rork done i use retired	ation during mos d)	t of worki	ing	16b. K	ind of Bu	siness/îr	ndustry	
ф	Elementary/Secor	ndary (0-12)	College	(1-4or 5+)		_		nce 1			Re	ealt	-y (co.	
C	17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	First, Middle	e, Maiden	Sumam	e)		
0 8	Osca	r Jame	es s						Blan	che J	acks	son			
	19a. Informant's Na	me/Relationshi	p (Type, Print)		19b. Maili	ng Addres	ss (Street	and Numb	er or Rura	al Route Numi	ber, City o	or Town,	State, Zi	ip Code)	702
	Anna E	. Jame	es (Wif	e)	823	5 Ne	ew Ha	amps	hire	Ave.	. H	att	svi	.11e.1	MD
- 1	20a. Method of Disp	osition		20b.	Place of Dispo				-	Date				own, State	
	1 □ Burial 2 □ 4 □ Donation		Removal from		te of				4	/12/0	4	3 i 1 tz	70r	Snri	ng,MD
	21. S mature of Fire		///	7					_	OWDEN					
	18n	12 K	Ans	wel						, Roc					
	23a. Part1. Enter the shock, or hear	e disease, or c	omolications thet	caused the dea	th. Do not ent	ter the mo	ode of dyin	ng, such as	cardiac o	or respiratory a	arrest,		1	Approxim	etween
	/		,										1	Onset and	d Death
	Immediate Cause (I			Metast	atic	Lunc	r Cai	ncer					:	Mon-	ths
	resulting in death)		a		or as a consec								i		
ner		892											F		
a m	Sequentially list con	autions,	D	Due to (of as a consec	querice J).						İ	_	
ŭ	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying													
ca	that initiated events resulting in death) L		C	Due to (d	or as a consec	quence of)):						+		
by Physician/Medical Examiner	resulting in death) L	.0.51											1		
an/			d										-		
일 왕	Part II. Other signific	cant condition	s contributing to	death but not res	sulting in the u	inderlying	cause giv	en in Part I		23b. Did	tobacco	изе соп	tribute	to the cause	of death?
ڇَ	Comm	unicat	ing Hy	drocep	halus					12	Yes 2	□ No	3 🗆 Pro	obably 4[Unknown
٦				T.											
leted t											s an autor	psy	24b. W	Vere autopsy vailable prio	findings
i e										porr	omica:		C	ompletion of death?	
Be Comp										10	Yes 2	CI No	1	□Yes 2	∃No
Ö	25. Was case referr	ed to medical						26 Place	of Dooth						
œ	examiner?		Hospital:		1 ED/O		Oth Oth	Or:		(Check only		. Dou	(0		
ို	1 Yes 3 1		1 1 _		ER/Outpatier		JUA	4 LI NU		me 5 Res 28d. Describe				"y) Hos	spice
5	1 Natural	5 Pending investiga		of Injury nth, Day Year)	Injury	м	28c. Injury Work	k? Yes 2□				,	-		
cal	2 ☐ Accident 3 ☐ Suicide	6 Could no	t be	o of Injury At h	ome form of					28f. Location	(Street or	nd Numbe	er or R	ral Route No	mher
dical Certification:	4 ☐ Homicide	determin	ed 286. Plac	e of Injury - At h ting, etc. (Speci	fy)	ieei, iacio	лу, оптсе			City or To			, or nur	ar noute Nu	moor,
<u>S</u>	29a. Certifier	NF Certifying	Physician: To th	e best of my kni	owledge deat	h occurre	d at the tin	ne, dete an	d plece	and due to the	Callen(e)	and mar	nner as	stated	
dica	(Check only one)	2 Medical E	caminer: On the I	pasis of examina	ation and/or in	vestigatio	n, in my o	pinion, dea	th occurr	ed at the time.	, date and	place, a	ind due t	to the cause	(s)

State

Registrar

29b. Signature

31. Date filed (Month, Day, Year)

MAR

Charles Harrison,

08 2004

6001

no completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

00071218

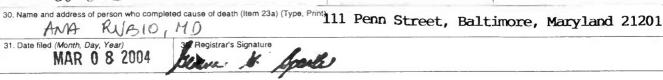
Muncaster Mill Rd., Rockville,

29d. Date signed (Month, Day, Yeer)

20855 MD

RUBIO 31. Date filed (Month, Day, Year) State MAR 0 8 2004 Registrar

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 1, 2004

TY JON	ES	For Amen	d Item#1 Unpend It	S	state o	f Ma	ryland	d / Depa	artment (of H	lealth	and M	l Copies lental Hy		וחמל	_	19621
Physici		1. Decedent's Na		e, Last)			v Jon			0, 1			2. Date of D Month MARCH	eath Da	y Yea	3.	Time of Death
/Medic Examin	_	4a. Facility Name							4b. City, To					4c	. County of De	eath	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Funeral Director		CALVERI 5. Social Security 218-90-4	Number	6. Sex	2DF		(In yrs. la	ast birthday) Yrs.	PRINC If Under 1	Year		er 24 Hrs.	8. Date of B	irth Pay, Year)	9.0 9.0 • 1964	Birthptace Country)	(State or Foreigh. DC
		Usual Residence					100 Cibe	, Town or Lo	antion	_			Decame		, 1001		Inside City Limit
oho.	ō	MD		vert			roc. Oily		e Fred	ori	ck						1 ∐ Yes 2 🛣 N
280	rect	10e. Street and N						11110	101. Zip C		.cax			10g. Cit	izen of What	Country?	
23a o		841 Ca	lvertov	n Dr	ive					206	7 8				USA		
or health and Mental hygene is the marked of the message or 28e-1 show item 27 is marked other then "natural", or item 23e or 28e-1 show other traumatic event, the Medical Examinar must be inclified at	by Funeral Director		mied 2 🔀 Mar 4 🗀 Divorceo	beir	Was Dec Armed Fo 1 Yes If Yes, Gi Year or D	orces? 2 ⊠No ive			Was Deceder If Yes, specify		ispanic C an, Mexic Specif		ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W Specify:		
natura lical E	ted	(Sn	15. Deceder					16a. Dece	dent's Usual (Occup	ation	ast of work	ina	16b. K	ind of Busine	ss/Industr	у
and mental rygiels. ie marked other then "r sumatic event, tra Med	Completed	Elementary/Se	condary (0-12)		College (-)	life.	erviso	retired					perty	Mana	gement
even even	Be	17. Father's Nam		Last)				т_					e (First, Middle	e, Maider	Sumame)		^
d Mental marked o matic eve	으	Clint		shin /Tvne	Print1				nes	Street		Shirle	⊇ y al Route Numi	her City (or Town State		Owens
27 ie r trau		Michell											Prince				20678
fitem 27 i		20a. Method of D	isposition				20b. PI	ace of Dispo	osition (Name	of		March			ocation - City		
= =			2 ☑ Cremation 5 ☐ Other (\$		oval from	State	-	_	matory		1		004	C	linton	, M	D
Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvers of Southern Maryland Blvd. Owings 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,															
yaician Medical raminer priugi-transit	al Examiner	disease or condi- resulting in death. Sequentially list if any, leading to cause. Enter United Section 1 to that initiated ever resulting in death.	conditions, immediate derlying or injury	b	Due to	(or as a	consequ	uence of):	cular D	1563	æ		•• ••				
attending phys for use as the	by Physiclan/Medica	IF FEMALE: 23b. Was deced in the past 1 ☐ Yes 9 ☐ Unknow	12 months? 2 ☐ No	23c		birth :	of pregnar 2 Fetal time of de	death 3	Ectopic preg		,				23d. Date of Month	delivery Day	Year
signed by the		Part II. Other sig	nificant condit	ions contri	buting to d	death bu	it not resu	ulting in the u	inderlying cau	ise giv	en in Par	t 1.		tobacco	. /		ause of death?
cate has been si page 2 should l	Completed													opsy formed?	24b. Were prior death	autopsy to comple es 2	findings availabilition of cause of
certificate rector, pag	Be	25. Was case re examiner?			spital:		VV	,		Oth	00		h (Check only				
h. After this funeral di	tlon: To	1 X Yes 2 27. Manner of De X Natural 2 Acciden	eath 5 Pend		28a. Date (Mor	Inpatier of Injur nth, Day		ER/Outpatie 28b. Time o Injury		. Injur			28d. Describe			pecify)	
after death. I Director: After d in by the fune	Certification:	3 Suicide 4 Homicid	6 ☐ Could		28e. Plac build	e of Injuding, etc	ry · At ho . (Specify	me, farm, st	reet, factory,	office			28f. Location City or To	(Street ar own, State		Rural Ro	ute Number,
n 24 hours afte ne Funeral Dir otetely filled in	Medical C	29a. Certifier (Check only one)	1☐ Certify XX Medica	ng Physic I Examine	r: On the i	basis of	examinat	wledge, deal tion and/or in	th occurred at rvestigation, in	the tir	ne, date pinion, d	and place, eath occur	and due to the	e cause(s e, date an) and manner d place, and o	as stated due to the	1. cause(s)
within 2 To the complete	W	29b. Signatu e a	nd title of certifi	me	y/r	ul	em	0			e numbe .M.E				ate signed (Mo	onth, Day 6 , 2(
		30. Name and and AMANYA	ddress of person	who com		ise of de				ree	et, E	Baltim	nore, M	aryl	and 21	201	

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Ma	ırylan	d / Depa <i>Cer</i>	artmei <i>tifica</i>	nt of H te of L	ealth a Death	and M	ental F	Hygier Reg. 1	ne 2 0	04	09625
	Dissolution		1. Decedent's Name (First, Middle, Last)								2. Date of Month		Day	Year	3. Time of Death
	Physici /Medic	_	Bridget		11y						Mar				10:25 p M
}	Examin	er	4a. Facility Name (If not institution, give si 45-T Ridge Road	treet and number)				rown, or reent		of Death		4	4c. County Prin		George's
	Funeral		5. Social Security Number 6. Sex		(In yrs.	last birthday)	If Unde	r 1 Year	If Under		8. Date of	Birth			place (State or Foreign
cak.	Director		578 - 22 - 7227	M 2⊠F	93	Yrs.	Months	Days	Hours	Min.	Dec.	<i>Day,</i> Yea 25,	910	Irel	and
	DG &		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation							1	10d. Inside City Limits
	Aaryla r sho	o	Maryland Prince Ge	orgeis		eenbel									1. Yes 2 No
	28a-	rect	10e. Street and Number	orge s	01	CCIIDCI		p Code				10g. (Citizen of W	/hat Cou	intry?
	h with	al Di	45 T. Ridge Road					2077	0			U.	S.A.		
	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturel", or items 23a or 28a-f show marked other than "naturel", or litems 23a or 28a-f show marked other than "naturel".	Funeral Director	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.	.S. 13. V	Vas Dece f Yes, spi	edent of Hi	spanic Ori	igin? (Spe	cify Yes or Rican, etc.)	No-		- Amer	ican Indian, , etc.
36	or it	by Ft	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 2√∑N If Yes, Give	0	1	I ☐ Yes	2₹ No	Specify:				Specify:		Nhite
	hour	ed b	15. Decedent's Educ	Year or Dates: ation		16a. Deced	lent's Usi	ial Occupa	ation			16b.	Kind of Bu	siness/li	ndustry
212	hin 72 In "ne Medis	Completed	(Specify only highest grade Elementary/Secondary (0-12)		+)	(Give :	kind of w DO NOT I	ork done d use retired)	<i>luri</i> ng mos)	t of workin	g				,
21.	ad with	Com	8			Homema	aker						wn Ho		
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)									dle, Maide	en <i>Sumam</i> e	9)	
Z	d Men narks	10	John Lardner	o Brinth		10h Mailin	a Addros	a (Street o		y Gav		mhar Cih	or Town, S	State 7	n Codel
Maryland 21215-0036	d 2 st th and traun traun		19a. Informant's Name/Relationship (Type Bernadette Kelly -				-						rylan		
	Heal		20a. Method of Disposition		20b. P	L lace of Dispos emetery, crem		-			ate	-	Location - (
Ë	Pages ent of nt: If i		1 N Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	moval from State		. Peter				3/9/2	2004	На	arpers	s Fe	rry, W.V.
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev DRCB.		21. Signatury of Funeral Service	PA	-	22	. Name a	nd Addres	s of Facilit	y Gas	sch's	Fune	ral E	Iome	, P.A.
m —	8978		Loguet 1	ay						Aveni	ie, H	yatts			D 20781
×			23a. Part1 Enter the disease, or complic shock or heart failure. List only one	ations that caused a cause on each line	the death e.	n. Do not ente	er the mo	de of dying	, such as	cardiac or	respirator	y arrest,			Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	End Stag			ers								
	/Medical Examiner		, and a second	Due to (or as a Dementia		uence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a		uence of):									
	cuted nd ransit	Examiner	that initiated events												
Ö,	cate be executed physicien and the burial-transit	Ex	resulting in death) Last	Due to (or as a	consequ	uence of):									
8760	cate b	dicai	d.												
9 X	death certificate be executed e attending physicien and id for use as the burial-transi	/Me	IF FEMALE: 23	c. If yes, outcome of	of pregna	incy		_					23d. Date	of delia	arv
Box	atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetal	Ideath 3 🗌	Ectopic p Other (s	regnancy pecify)				_]	Mon		Day Year
o.	t the c by the	hysi	9 □Unknown	9□ Unknown											
S, D	The law requires that the de ate has been signed by the a page 2 should be detached t	by P	Part II. Other significant conditions cont	77	t not resu	ulting in the un	nderlying	cause give	n in Part I.		4				he cause of death?
ord	w require been sig should b	ted	Atrial Fibrillation	1							1.	□ Yes	2 □ No :	3 🗌 Pro	bably 4 X Unknown
e C	has be	Completed	Osteo Arthritis								24a. W	topsy	pr	nor to co	opsy findings available empletion of cause of
E E		Con									1□ Ye	erformed? s 2∭N		eath?	2□ No
Vital Records,	siclen: The certificate hirector, page	o Be	25. Was case referred to medical examiner?	ospital:		50/0	400	Othe	c		(Check on		. 50:		
ō	this ald	-	1 ☐ Yes 2 ☒ No 27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury	,	ER/Outpatient 28b. Time of		28c. Injury	at Nu				6 Othe		(y)
Division of	nding f ath. r: After e funer	ation	1 Accident 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	М	Work 1 □ Y	? ′es 2	No					
N N	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At ho	ome, farm, stre	et, facto	y, office		2		n (Street a		r or Rur	al Route Number,
ā	pital or A ours after leral Dire filled in by														
		edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Exemination	cien: To the best of er: On the basis of and manner stat	examinal	wledge, death tion and/or inv	occurred estigation	dat the time n, in my op	e, date an inion, dea	d place, a th occurre	nd due to t d at the tim	he cause(ie, date a	(s) and man nd place, a	iner as s nd due t	stated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of pentitier	and manner stat	ba l		29	c. License	number			29d. D	ate signed	(Month,	Day, Year)
	F 3 F 5		» // S//h/	nun	m)		D005	1473			Mai	rch 5,	, 20	04
	(5)		30. Name and address of person who con									1			
	9		Kathy Brenneman, M			um St.,		E. #0:	21, W	lashi	ngton	, DC	20017	/ 	
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 0 8 2004	32. Registra	r's Signa	ture	4								

	3	Ĩ,	1 - For State Registrar 1. Decedent's Name (First, Middle, Last,	State of Ma	aryland /	Depa	ırtmen tificatı	t of H	ealth a	nd Mei	ntal Hyg	giene 2 0	104	0 9 6 2 6
The state	Physici /Medio Examin	cal	SUSIE KIT	Street and number)			4b. City	Town or	Location of		Month	Day 4- Z	Year	1215 A M
1	Examin	ier	Holy Cross Ho				vo. oxy,						_	
2	Funeral		5. Social Security Number 6. Sec		(In yrs. last	birthday)	If Under	1 Year	ver Sp If Under 2	4 Hrs. 8.	Date of Birth		1ontome 9. Birthpled	gery ce (State or Foreign
	Director		244-58-9331 Usual Residence of Decedent]M 2 X]F	65	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year)		Carolina
	n 72 nours alter death with the Maryland "natural", or Items 23a or 28a-f show suical Examinan must be colified at	Director	10a. State 10b. County D. C.		10c. City, To	own or Loc	Was	hing	ton					Inside City Limits 1 Yes 2 No
	Min Will		10e. Street and Number				10f. Zip	Code			1	0g. Citizen of	What Country	17
	18 23	era	3173 Westover D	rive, S.E. 12. Was Decedent B		12.14	Van Daniel	1 1 - 6 1 C	2002		. V N		ed Sta	
20	irs arter or if, or item varniner i	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		1	Yes, spec		spanic Origi n, Mexican, Specify:	Puerto Ric	/ Yes or No- an, etc.)		ce - American ck, White, etc	
o i	na na	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>		(Give I	ent's Usua kind of wor OO NOT us	k done d	urina most o	of working		16b. Kind of B	usiness/Indus	stry
7	within then the Med	E	Elementary/Secondary (0-12)	College (1-4or 5	+)			,			}	70		
0	E F E E	O	17. Father's Name (First, Middle, Last)	0			CSW,	1,10		s Name (F	irst, Middle, M	Maiden Suman	rivate	
	0 to 0 to 0	To Be	Louie Richard	dson							Ida Mc(,	
<u> </u>	th and Ment 7 is marked traumatic	F	19a. Informant's Name/Relationship (Ty		1	9b. Mailin	g Address	(Street a	nd Number			City or Town,	State. Zip Co	ode)
	コモトコ	İ	Michael N. Kib	ler - Son								ash., D		
ē.	is 1 and is 1 tem 27 other tr		20a. Mathod of Disposition		20b. Place	of Dispos		ne of		Date		20c. Location -		
Ë,	8 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			.1 Cer			3/11/2	2004	C+ 1	and M	m
Baltimore,	permit. Pa Departmen Importent: any injury once.	1	21. Sign were of Funeral Service Licens	эө ()	Geda				s of Facility			Suiti Funeral	and, M	Ш
ă	Departr Departr Importe any inji		I lot IT ST	evont i	TT					DCC		ish., D		10
E	hysician /Medical ician and prician and pricial-transit	Examiner	23a. Par(1. Enter the disease, or complishook, or heart failure. List only or Immediate Gause (Final disease or condition resulting in death) Saturatially list renotions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a	a consequence	e of):			ks				In Oi	pproximate terval Between nset and Death
- :	attending phys for use as the	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Petal dea	5 🗆	Ectopic pre Other (spe	ecity)				23d. Dat	e of delivery	y Year
rus,	been signed by the should be detached		Part II. Other significant conditions con Author Roy Py		t not resulting	in the und	derlying ca	iuse givei	n in Part I.					ause of death? y 4 Unknown
DIVISION OF VITAL DECORDS,		Completed by	Polycy Minis PuB	nd nery							24a. Was an autopsy perform	red?	Were autopsy prior to complete th?	findings available etion of cause of
	certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:						Death (C)	heck only one	9)		
	n. After this c funeral dir	tlon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day	285	Outpatient Time of Injury		Bc. Injury Work	4 LI Nursi	28d.		nce 6 Dothe w injury occurr		
DIVISION OF VICE	within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	ry · At home, (Specify)	farm, stre			03 2	28f.	Location (Str. City or Town,	eet and Numbe State)	er or Rural Ro	oute Number,
ejeconie	within 24 hours To the Funerell completely filled	Medicai (29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examir	ician: To the best of ter: On the basis of and manner stat	examination a	ge, death	occurred a estigation,	it the time in my opi	e, date and p nion, death	place, and occurred a	due to the ca t the time, da	use(s) and mai te and place, a	nner as stated and due to the	d. cause(s)
,	To To To To To To To To To To To To To T	Z	29b. Signature and title of certifier	1			29c.	License	number		29	d. Date signed	(Month, Day	, Year)
				1				DL	1675			much	4 20	Ye,
	(7)		30. Name and address of person who co		. ^	1 .	rint)	L	Ball	242	m	D	1	,
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 0 2004	2. Registrar		Lan	000	74	() ()	vagn	7			

	1 - For State Registrar		artment of Health and rtificate of Death	Mental Hygiei	2001, 000
hysician	1. Decedent's Name (First, Middle, Last) Herbert Kilby			2. Date of Death Month	Pay Year 3. Time of De
/Medical Examiner	4a. Fecility Name (If not institution, give street and r		4b. City, Town, or Location of De	ath	4c. County of Death
uneral rector	5. Social Security Number 5.77-26-4871 6. Sex 1 M 2 F	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H Months Days Hours Mi	S. 8. Date of Birth	Anne Arund 9. Birthplace (State or F Country) 1924 Maryland
ehow stat	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			10d. Inside City I
"naturel", or itame 23s or 28s-f eho olical Exeminar must be notified at leted by Funeral Director	Maryland Prince George 10e. Street and Number	e's District	10f. Zip Code	10g.	Citizen of What Country?
iera!	1845 Tanow Place	ecedent Ever in U.S. 13.	20747		S . A . 14. Race - American Indian,
by Funeral	1 Never Married 2 Marned 1 Yes	s 2 No 1943-	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 ☐ Yes 2 🏋 No Specify:	erto Rican, etc.)	Black, White, etc. Specify: White
Completed	15. Decedent's Education (Specify only highest grade complete: Elementary/Secondary (0-12) College	(Give life.	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking	. Kind of Business/Industry
Re Con	17. Father's Name (First, Middle, Last)	Prin		ame (First, Middle, Maid	olumbia Planograp den Sumame)
70	James Franklin Kilby		0sceol:	a Arnold	
14	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or		
	Ellen Blizard - Daughte		Turnwood Drive, (sition (Name of matory or other place)		MD 21061 Location - City or Town, State
To Be Comp	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	IIII State I	matory or other place) al Memorial Park 3/		
any injury or othar trai	21. Signature of Funeral Service Licensee		2. Name and Address of Facility G		
a	23a. Pant. Enter the disease, or complications a shock, or heart failure. List only one care		739 Baltimore Ave		ille, MD 20781 Approximate
ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease of what initiated events c.	to (or as a consequence of): to (or as a consequence of):	ionary a	tery d	interval Betwee
Polical	in the past 12 months?	egnant at time of death 5 [□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Yea
	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of deal
Completed				24a. Was an autopsy performed	
Re	25. Was case referred to medical examiner? Hospital:	×	Othor	eath (Check only one)	/
e funeral director, page 2	1 Tes 2500	X Inpatient 2 ☐ ER/Outpatient te of Injury 28b. Time of Injury 28b. Time of Injury 100th, Day Year)	IL 3 DOA 4 Nursing	Home 5 Residence	
Certification.	3 Suicide 6 Could not be determined 28e. Pla but	ace of Injury - At home, farm, stillding, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number ate)
completely filled in by the funeral director, page 2 should be detached for use as the Madical Certification: To Re Completed by Physician/Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat e basis of examination and/or in anner stated.	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
comp	29b. Signature and title of certifier	- 1 mD	29c. License number 248006		Date signed (Month, Day, Year) Chich 7, 700
1/2	30. Name and address of person who completed ca	ause of death (Item 23a) (Type,	Print)	colo	Burntin

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** YONG CHUN KIM 1:20 PM MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors' Community Hospital Lanham | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or recountry) | Months | Days | Hours | Min. | June | 25, 1940 | South | Korea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** 1⊠M 2□F 63 217-04-1917 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 28a-f show 10a. State 10b. County 1⊠Yes 2□No New Carrollton Maryland Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20784 South Korea 6001 84th Avenue Items 23a Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene. by Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: Asian ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) d other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) al Hygiene. School Supplies Entrepreneur 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If item 27 is marked out any injury or other traumatic ever once. Gyoung Min Ahn Jin Kim Gaeb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Casey C. H. Kim/Daughter 6001 84th Avenue, New Carrollton, Maryland 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Lakemont Memorial Gardens 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 20904 HINES-RINALDI FUNERAL HOME, 11800 New Hampshire Avenue, Silver Spring, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** 1 Day 560415 resulting in death) /Medical Due to (or as a consequence of): Examiner 11364 NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 physician Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ ENCEPHALOPATRY cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? CONEBRAL INFARCTION 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After To the Hospital or Attendury
within 24 hours after death
to the Funeral Director: Alt 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D01852 MARCH 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)-Uttous DURY Red HYATISVIII MID 20187 4203 EVORE MIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 8 2004 Registrar

physicien P.O. Box 6876 Hospital or Attending Physician: The law requires that the death certificat Division of Vital Records, s been signer his certificate has bill director, page 2 s hours after death.
Ineral Director: After this y filled in by the funeral di 24 hours a Funeral (

, or Items 23a or 28a-f show

"naturel",

I Hygiene. other then

other

filed within 72 hours after

Baltimore, Maryland 21215-0036

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1742054 MARCH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg Donaldson M.D.

912 Seton Drive Cumberland MD 21502

22, 200 Y

State Registrar

completely

within 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death		Reg. No.	004 0	963
hysician [*] /Medical	1. Decedent's Name (First, Middle, Last) 205 & Locke	2. Date of De Month	Dey	Year	ne of Death
xaminer	4a Fecility Neme (If not institution, give street end number) Southern wary liend Hospital Crinton	ocation of Deetl	4c. County		78.
neral ector	5. Social Security Number 579-42-3301 6. Sex 1 Months 1 M 2 F 7. Age (In yrs. lest birthdey) 1 Months Days Hours Min.	8. Date of Bir (Month, De May /,		9. Birthplace (Si Country) Orangeb	
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State				de City Limits
be notified	10e. Street end Number 10f. Zip Code		10g. Citizen of	What Country?	
from must	4605 Cedell Place 20748 11. Maritel Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (Sp	7		States	
Examiner by Fun	11. Maritel Status 1 □ Never Married 1 □ Never Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Sive Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Sp if Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	Rican, etc.)		ce - American India ck, White, etc. y: Black	ın,
it, the Medical	15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) 11th 15a. Decedent's Usuel Occupation (Give kind of work done during most of work life. DO NOT use retired) Custodian	ing	16b. Kind of B	usiness/Industry	
Be C	17. Father's Neme (First, Middle, Last) 18. Mother's Name	e (First, Middle,			
10	Daniel Abraham Frazeli				
5	19a. informant's Name/Relationship (Type, Print) Anthonette Locke / Daughter 19b. Mailing Address (Street and Number or Run 4605 Cedell Pl. Templ	e Hill,	or, City or Town, Md • 20	State, Zip Code) 0748	
5	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) Lincoln Cemetery 3	Date /13/04	20c. Location -	City or Town, Stat	6
ny inc	21. Signature of Funeral Service License 22 Name and Address of Fecility Alexander 5. Pope	Funera			
60	April Sance Morre 5538 Marlboro Pik	e/fores	tville,	Md. 207	47
ian cal	23a. Per Carler the Iser's or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only on cause on each line. Immediate Cause (Final disease or condition	or respiratory ar	rest,	Approxi Interval Onset a	Between and Death
er _	Due to (or as a consequence of):	`			,
Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of): Due to (or as a consequence of):			2.0	weely
8	Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of):				
Physician/M	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	ook Dida			
by Physic	Diabetes Mellitus type 2.	230. Did ti	,	atribute to the cau	
Completed by		24a. Was a	in autopsy med?	24b. Were autop available pr completion	ior to
Comp		1 🗆 Y	es 2 🗆 (No.	of deeth?	2 🗖 No
BeC	25. Was cese referred to medical examiner? 26. Place of Death			10 163	2,20(110
1.10	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor				
ation	11 Naturel 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	.ou. Describe No	ow injury occurre	0 0	
Certification:	3 ☐ Suicide 4 ☐ Homicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si City or Town	treet and Numbe n, State)	er or Rural Route N	iumber,
	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, a course and manner steted.	and due to the co	euse(s) and mar ate and place, a	nner as stated. and due to the caus	se(s)
W W	29b. Signature and title of certifier 29c. License number	2	9d. Date signed	(Month, Dey, Yee	r)
,	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) O Litery & 9131/15ccat away 11 d Unitary my		3/8	104	
)	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) O Hoya 9131/15cataway 11 d Clinton my	r	1		
State	31. Date filed (Month, Day, Year) MAR 1 1 2004				

State of Maryland / Department of Health and Mental Hygiene 004 09631 State RegistraMEND ITEM #1 PER PHY G830 4/07/04 JRCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 **Physician** CHUN TAO CHOW LUI March 2 Chun Tao Lui 1:20A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jan. 25, 1918 9. Birthplace (State or Foreign Country) China 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 🙀 F Yrs. 213-96-6417 86 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Directo Maryland Rockville Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 0 6060 California Circle #509 20852 U.S.A. natural', or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Asian Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed withit Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Chu Chow Yu Quan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14301 Gains Ave., Rockville, MD 20853 Yee Sit daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition injury or of 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-6-2004 Gate of Heaven Cem. Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licenses 11800 New Hampshire Av., Silver Spring, MD 20904 Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebral Atherosclerosis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liscass or mild y that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Por Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 21XNo detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 1 ☐ Yes 2 X No P 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pendina 1 X Natural death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D27865 March 2, 2004 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 1721 University Blvd. West, Wheaton, MD 20902 Mark K. Li, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racker MAR Registrar 0.8 2004

			1 - For State Registrar	State of Ma	ryland / Depa	artment of I	Health and M	Mental Hygi	ene 2004	09632
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last CLARA CLARA 4e. Fecility Name (If not institution, give 10120 New Hamp	E. L	UCKETT e. #309		or Location of Death		4, 2004 4c. County of Deeth MONTGOM	3. Time of Death 6:30 PM
120	Funeral Director		Usual Residence of Decedent	M 2€ F	(In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 3	9. Birth Cou 0,1918 M	place (State or Foreign ntry) aryland
	the Marylar r 28e-f show	rector	10a. State 10b. County 10b Montg		10c. City, Town or Lo	er Spri	ng	100	g. Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show among injuryer other treumatic event, the Medical Examinar must be notified at ance.	ed by Funeral Director	10120 New Hamp 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evaluated Forces? 1 ☐ Yes 2 Note of Year or Dates:	ver in U.S. 13.	Was Decedent of H f Yes, specify Cub 1 Yes X No	Hispanic Origin? (Span, Mexican, Puend Specify:	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Americ Black, White,	ean Indian, etc. lack
Maryland 21215-0036	e filed within 72 Il Hygiene. other than "ne vent, the Medic	Be Completed	(Specify only highest grad Elementary/Secondary (0-12) 8 th 17. Father's Name (First, Middle, Last)	e completed) College (1-4or 5+	(Give	kind of work done DO NOT use retire Omemake	during most of work d)	e (First, Middle, Ma	Home	dustry
Maryiar	d 2 should be th and Menta 7 is marked treumatic ev	To B	Unknown 19a. Informant's Name/Relationship (7) Juanita E. Byr						City or Town, State, Zip	
Baltimore, I	permit. Pages 1 and Department of Healt Important: If Item 2' any injury or other 1 once.		20a. Method of Disposition 20a Method of Disposition 20a Method of Disposition 3 F 4 Donation 5 Other (Specify) 2 Signature of Funeral Scyce Lice	temoval from State	20b. Place of Dispo cemetery, crent Arlingt	sition (Name of natory or other place) CON Nat: Name and Addre	ional 3/	12/04 10wden F	nersburg, Dc. Location - City or To Arlingtor Uneral Ho	own, State 1 , VA DME PA
	Physician /Medical		23a Part1. Enter the disease, or compl shock, or hear failure. List only of Immediate Cause (Final disease or condition resulting in death)	Deep	venous Toonsequence of):	er the mode of dyir	ng, such as cardiac	or respiratory arres	kville,MI	Approximate Interval Between Onset and Death
68/60,	ate be executed hysicien and hysicien and ihe burial-transit	licai Examiner	Sequentially list conditions, I ary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d	consequence of):					
O. BOX 6	tt the death certificate by the attending physitached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,	200	23d. Date of delive Month	ry Day Year
coras, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con Depression		not resulting in the un	iderlying cause giv	en in Part I.	I	2 No 3 Prob	
d)	The law ate has b page 2 si	e Completed	Seizure Dis	order				24a. Was an autopsy performe 1 ☐ Yes 2 ☑	prior to con	osy findings available inpletion of cause of
5	ng Phys fter this neral dii	ertification; To Be	examiner?	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	(eer) 28b. Time of Injury	28c. Injun Worl M 1	er: 4 □ Nursing Hor y at k? Yes 2 □ No	28d. Describe how		
2		0	4 Homicide determined	building, etc. (City or Town, S	at and Number or Rural State) se(s) and manner as stated and place, and due to	
	To the Hospitel or within 24 hours aft To the Funeral Discomplately filled in	Medical	29b. Signature and title of certifier		Ninale	29c. License D 4 5		29d.	and place, and due to Date signed (Month, L Mar. 4, 2	Day, Year)
	Sta Registra		30. Name and address of person who co Wilkinson J. 31. Date filed (Month, Day, Year)		M.D. 34			lvd., Si	ilver Spr	ing,MD

				State of Man	vland / Depa				9	
			1 - For State Registrar AMEND#7perFH3/8		0-	rtificate of			2004	09633
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	Karen Mae Linthicu			4h City Town o	r Location of Death	February	26, 2004 4c. County of Death	8:45 P M
lt	Examir	ner	Washington Adventi		. 1	Takoma P			Montgomer	57
	Funeral		5. Social Security Number 6. Sex	7. Age (I	n yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		y plece (State or Foreign ntry)
	Director		219-46-8666 Usuel Residence of Decedent	M 2XTF	96. 99 Yrs.				5, 1948 Ma	
	yland		10a. State 10b. County	10	Oc. City, Town or Lo	cation			1	Od. Inside City Limits
	8a-f s	Director	Maryland Montgome	cy S	Silver Sp					1 X Yes 2 ☐ No
	with the a or 2		10e. Street and Number			10f. Zip Code		100	. Citizen of What Cour	ntry?
	death ms 23	Funeral	429 University Blvc	12. Was Decedent Eve	er in U.S. 13. 1	20901 Was Decedent of H	ispanic Origin? (Sp In, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Americ	can Indian,
9	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		if Yes, specify Cuba 1 □ Yes 3 √□ No	n, Mexican, Puerto Specify:	Rican, etc.)	Black, White,	
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than *natural', or items 23e or 28e-f show event, The Medical Examinational be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:		dent's Usual Occup		140	Specify: Whi	
215	within 72 ene. than "nai	Completed	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	ation during most of work f)	ing	b. Kind of Business/In	austry
212	filed with Hygiene. Ither than	Com	12	College (1-401 54)	Hom	emaker			Own Home	
Maryland 21215-0036	should be fill nd Mental H marked oth	To Be	17. Father's Name (First, Middle, Last) Harry William Figge	ers			18. Mother's Name Juanita	e (First, Middle, Ma Meade	iden Sumame)	
Man	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic erones.		19a. Informant's Name/Relationship (Typ						City or Town, State, Zip	
ē,	s 1 and I Healt item 2 other		Roger L. Linthicum 20a. Method of Disposition	-	20b. Place of Dispo				c. Location - City or To	
Baltimore,	Page nent o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	T I	Loudon Pa		1	29/2004 В	altimore, I	MD
3alti	permit. Departr Imports any inju		21. Signature of Juneral Service License		22	. Name and Addres	ss of FacilityHine	s-Rinald	i Funeral 1	Home
111	205 # S	10. 1	a series south discourse a constitution	UL					ver Spring	
100	Physician /Medical		23a. Part1. Efter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. Due to (or as a co	LR OF	Lux		or respiratory arrest	,	Approximate Interval Between Onset and Death
ľ	Examiner		Sequentially list conditions.							
	ted nsit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	or sequence of):					
Ć	ate be executed sysician and he burial-transit	Exar	that initiated events c resulting in death) Last	Due to (or as a co	onsequence of):					
	ate be nysicia he bur	icai	d							
x 68	leath certificate attending phy I for use as the	/Med	IF FEMALE:	3c. If yes, outcome of p		7.72			1	
P.O. Box	0 0 0	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)			Month	ny Day Year
	that the	y Ph	Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute to th	e cause of death?
rds	wrequires that the de been signed by the s should be detached	ed b						1 ☐ Yes	2 □No 3 □ Prob	ably 4 Dunknown
of Vital Records,	The law requires that the sate has been signed by the page 2 should be detached.	Completed						24a. Was an autopsy	prior to cor	osy findings available inpletion of cause of
B		e Cor	25. Was case referred to medical					performed		2 No
\leq	Physician: r this certifica ral director, j	To Be	examiner?	ospital:	2 ER/Outpatien	t 3 DOA Cthe	AP:	n <i>(Check only one)</i> me 5 ☐ Besidenc	e 6 □Other (Specify	d
0	ng Ph fter th meral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injury Work	-	28d. Describe how		,
Division	Nttendi death. ctor: A y the fy	icati	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury	At home form etra		res 2□No	39f Location (Ctros	Annal Mumbar or Dun	Courte Museum
Div	after after I Direct	Certification:	4 Homicide determined	building, etc. (5	Specify)	эет, тастогу, отпсе		City or Town, S	it and Number or Rura. State)	Houte Number,
	To the Hospital or Attending Physician: whithis 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai C	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of mer: On the basis of exand manner stated	amination and/or inv	occurred at the time restigation, in my op	e, date and place, a pinion, death occurre	and due to the caus ed at the time, date	e(s) and manner as stand due to	ated. the cause(s)
L.	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Month, L	Day, Year)
•	V		Jenn M			30	391	FG	BRUARY 2	8 2004
			The state of the s	npleted cause of death	F) - 13	Print) ELL REST	Po, H	497101/14	MD 2	C9+L
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 200	32. Registrar's		Sporks		1		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** MARCH 4, 2:55 P M HULL LEVYNE 2004 MARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Director 156-34-3998 MARCH 4, 1943 **NEW YORK** 61 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 28e-f show Example of rough by natified at 1∰ Yes 2□No Directo ROCKVILLE MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 20852 UNITED STATES items 23a 5815 EDSON LANE, #T-2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **(X**No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: by Specify 3 ☐ Widowed 4 ☐ Divorced WHITE "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ PSYCHOLOGIST JEWISH SOCIAL SERVICES other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental F importent: If item 27 is marked of any injuryor other traumatic even once. HULL **TANYA** ZERUDNY ROBERT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD B. EDLAVITCH, HUSBAND 5815 EDSON LANE, #T-2 ROCKVILLE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State NATIONAL CREMATORY 3/7/2004 FALLS CHURCH, VA ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²DANZANSKY-GÖLÜBERG MEMORIAL CHAPELS, INC. Donald (1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASPIRATION PNEUMONIA Immediate Cause (Final disease or condition Physician resulting in death) /Medical **Examiner** INTRACTIBLE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760, Physiclan/Medical the IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ٥. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à NEUROENPOCRIN HYPERPLASIA 1 Yes 2 No 3 Probably 4 Unknown Completed FIBROSING 24a. Was an autopsy performed? RADIATION INDUCED SICA SYNDROME 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No BRONCHIOLITLS 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1€ Yes 2 No Certification: To 2€ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire To the Hospitel textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print) FEENWOOD RD #401 BETHESOA, MD 20817 MD 10215 31. Date filed (Month, Day, Year) 32. Registrar's Signature sacks

Registrar

MAR 09

			For State Registrar	State o	f Marylan		artment rtificate				ental Hyg	iene	200	4 09	635
	Physici		Decedent's Name (First, Middle, Janet Eve.		,						2. Date of Dea Month March	Day	Year 004	3. Time o	f Death
ž.	/Medio Examin		4a. Facility Name (If not institution, g	give street and nur	mber)				Location of	of Death	nazen .	4c. C	County of Dea	ath	
	Funeral		Montgomery General Security Number 6	. Sex	7. Age (In yrs.	last birthday)	Olr If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day		ntgome 9. Bi	rthplace (State (country)	or Foreign
	Director		577-36-3961	1 ☐ M 2 🔀 F	90	Yrs.	Months	Days	Hours		July 24			irginia	
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	ity Limits
	a-fsh	ctor	Maryland Montg	omery		01ney								1 🗆 Yes	2 ∑ No
	vith th	Funeral Director	10e. Street and Number				10f. Zip				1		en of What C	ountry?	
	ns 23c	erai	17180 Macduff A		edent Ever in U	.S. 13.	Was Deced	208 ent of Hi		ain? (Spe	city Yes or No-		SA 4. Race - Am	erican Indian,	
920	urs after d al', or itan	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	rces? 2⊠No /e		lfYes,spec 1 □ Yes 2		n, Mexican	i, Puèrto	city Yes or No- Rican, etc.)		Black, Wh	ite, etc.	
Maryland 21215-0036	permil. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show many injury or other traumatic event, the Medical Examinating Ite notified at DAGS.	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12)		-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired	ation during mosi)	t of worki	ng	16b. Kind	d of Business	s/Industry	
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and	Mental H Merked of arked of	To Be	Nelson Vaughn F								. Deishe		urrame)		
ary	should and Men s marke umatic	F	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			I Route Number		Town, State,	Zip Code)	
	and 2 ealth a m 27 is		Robert C. Flaher	ty/ Brot	her	1712	0 Mac	duff	Ave		Olney,				
Baltimore,	Pages 1 nent of Hi int: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		State	Place of Dispo cometery, crer			! 1	larch		20c. Loca	ation - City o	Town, State	
H	permit. Page Department of Important: If any injury or once.		 4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lice 		St.	John'	2. Name and	d Addres	s of Facilit	200)4			ing, M)
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	Physician		23a. Part1. Enter the disease, or co shock, or heart tellure. List or Immediate Cause (Finaf disease or condition	_	aused the death ach line.	h. Do not ent	er the mode	e of dying	g, such as PAIL	cardiac o	r respiratory arr	est,		Approximat Interval Bet Onset and	te tween
	/Medical Examiner		resulting in death)		or as a conseq	uence of):			, , , , _						17.3
	Maring and	e	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseq		NON	AU	E					LMO X	EAR
	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c											
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9	eath certifica attending ph I for use as th	/Med	IF FEMALE:	23c If yes out	come of pregna	ancy						-			
.O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1□Live b	irth 2 ☐ Feta ant at time of d	Ideath 3□	Ectopic pre Other (spe					23	ld. Date of de Month		Year
ď	res that igned b be deta	by Pr	Part II. Other significant conditions	s contributing to de	eath but not res	ulting in the u	nderlying ca	tuse give	n in Part I.		23e. Did tot	acco use	a contribute t	o the cause of c	leath?
ğ	w require been sig should b										1 🗆 Ye	s 2 🚾	No 3□P	robably 4 🗆	Jnknown
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Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	AF.		(Check only on				
	Phys or this oral di): To	1 ☐ Yes 2 No 27. Manner of Death	ושא	npatient 2 of Injury th, Day Year)	28b. Time of		A Bc. Injury Work	4 LINU		ne 5 ☐ Reside			ecify)	
lo lo	Attending I r death. ector: After by the funer	atior	1 Anatural 5 □ Pending 2 □ Accident investigat		th, Day Year)	Infury	М		(? Yes 2 □ i	No		. ,			
Division of	tai or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ad 289. Place	of Injury - At hong, etc. (Specify		eet, factory,	, office		2	28f. Location (St. City or Town		Number or R	ural Route Num	ber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical (29a. Certifier 1 Certifying (Check only one)	Physician: To the aminer: On the ba	best of my kno asis of examina ner stated.	wiedge, death tion and/or in	n occurred a vestigation,	at the tim in my op	e, date and pinion, deat	d place, a	and due to the ca	iuse(s) a ate and p	nd manner a lace, and du	s stated. e to the cause(s	a)
	To the within 2 - To the complet	ž	29b. Signature and title of certifier				29c.	License	number		2	d. Date	signed (Mon	th. Day, Year)	
	4		R.W.HW	w-	_13			231	124		N	ARC	H5.	2004	,
			DENNIS M. HAC	o completed caus	e of death (fter	n 23a) (Type.		.CA	VOY '	SPD	INF 180	20	DINE	y MA	PM AUT
3	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8	32. R	egistrar's Signa	iture &	Sp	ak	2			17L)	DUVE	1 1 11/1	~.IN/hi

808 Horton Place Silver	Mar or Location of Death Spring	of Death with Day 2004 4c. County of Deat Montgome	10:30 A M
808 Horton Place Silver	Spring		th
Funeral 187 M 20 F FO West Months Days	Mar		ry
Usual Residence of Decedent		ch 14,1944 was	10d. Inside City Limits 1 □ Yes 2 🕍 No
Maryland Montgomery Silver Spring 100. Street and Number 100. Zip Code 808 Horton Place 2090	02	10g. Citizen of What Co	
© = □ 1 M Never Married 2 Married 1 DVec 2 M No	dispanic Origin? (Specify Yes an, Mexican, Puerto Rican, e Specify:	0	
The proof of the p	during most of working	16b. Kind of Business	
Tr. Father's Name (First, Middle, Last) Herman T. LaCrosse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	18. Mother's Name (First, I Maryann Bu		Zin Codel
Natalie A. DeVol/ Sister Solid State St	., N.W. Washi	ngton, D.C. 20	0016
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Fureral Service Lights 22. Name and Addre	March 11 2004 ss of Facility DeVol F 2222 Wiscon	Silver Spri uneral Home sin Ave N.W. D.C. 20007	ng,Maryland
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line. Physician Inanition			Approximate Interval Between Onset and Death Weeks
Examiner Senile Dementia			years
The state of the s			years weeks
So of the population of the po	у	23d. Date of de Month	livery Day Year
හි ස සිමු <u>යි</u>	ven in Part 1. 23e	Did tobacco use contribute to	o the cause of death?
		autopsy prior to performed? death?	utopsy findings available completion of cause of 2 No
27. Manner of Death 1 1 1 2 2 2 2 2 2 2	y at 28d. Des	anly one) Residence 6 Other (Specifie how injury occurred	icify)
27. Manner of Death 27. Manner of Death 28. Date of Injury 28. Tim	City	ation <i>(Street and Number</i> or Ri or Town, State)	
The state of the s	ppinion, death occurred at the	time, date and place, and due	e to the cause(s)
29b. Signature and title of certifier 29c. Signature and		March 8, 20	
John E. Glancy, M.D. 1731 Briggs Chaney Rd. S State Registrar MAR 10 2004		MD 20905-5529	9

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2004 **Physician** March 5, William Adolph Leser 8:40 а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1XM 2□ F Days Hours Min. Mary Land Director 215-30-1256 70 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No Prince George's Maryland College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itams 23a 3511 DePauw Place 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Apped Forces? 1 A Yes 2 □ No 1952 — If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 X Widowed 4 □ Divorced Specify: natural, White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Prince George's Cty. Elementary/Secondary (0-12) Il Hygiene. other then College (1-4or 5+) Fire Fighter Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1
Department of Health and Mental I
Important: if item 27 is marked or
eny injury or other traumatic eve Frank George Leser Helen Elizabeth Hall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra L. Funkhouser - Daughter 3511 DePauw Place, College Park, Maryland 20740 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

* 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 3/9/2004 Brentwood, Maryland 21. Signatus of Funeral Service Licer 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Enter the disease, or complications that cau set the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Hours resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760. the SS IF FEMALE use : 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ briknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🔀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient Certification: To 2 ER/Outpatrent 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 2 Accident after death Diractor: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Z Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50791 March 6, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Drive, Silver Spring, Maryland 20902 Damirez Fossett, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 2004 Registrar

•••	* yw		For State Registrar	State of	Marylan		artment of F	lealth and N Death	Mental Hy		2004	09638
	Physici		1. Decedent's Name (First, Middle, L		lton L	ucas			2. Date of De Month March	eath Day	Year	3. Time of Death 10:10p M
	/Medio Examin		4a. Facility Name (If not institution, g Washington Ad	ive street and num	nber)		4b. City, Town, o Takoma	r Location of Death		4c.	County of Death	
Ť	Funeral Director		578 22 9145	Sex 1□M 2□F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Di Nov. 1	rth ay, Year) 1th.	9. Birth Cou	place (State or Foreign intry) N . C .
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	h with the 23a or 28a rat te not	ai Director	10e. Street and Number 2221 Shepherd	Street,N.	Ε.		10f. Zip Code	20018		10g. Citiz	zen of What Cou USA	intry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Heath and Mental Hygiene. If flem 27 is marked other then "natural", or Itema 23a or 28a-f show or other traumatic event, the Madical Examinar mark to notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For Was Yes If Yes, Give Year or Da	2 □ No e		Was Decedent of H f Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (St an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		14. Race - Amer Black, White Specify: B1a	, etc.
21215-0036	within 72 ho iene. 'then "natur ine Madical I	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 12years		4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired W Enforce	during most of world)	king		nd of Business/li vernment	,
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Maryland	1 and 2 shoul Health and Mi tem 27 is marl other traumati		19a. Informant's Name/Relationship Marilyn Turne	<i>(Type, Print)</i> er / Daug	hter			and Number or Ru n Drive U				
Baltimore,	permit. Pages 1 a Department of He. Important: If item any injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec	Removal from S	20b. P	emetery, crei	sition (Name of natory or other place coln Ceme	etery 3/0	Date 8/2004		entwood,	
Balt	permit. Page Department of Important: if any injury or		21. Sonature of Funeral Service LC	mile		3		Jo Street,N	.E. Was	hignt	Funera	
8760,	Physician /Medical Examiner but steep partial street but street bu	dicai Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. Due to (ach line. LIDIO or as a consequence of the conseq	PWW uence of): My uence of): SUET	10NAD	y ARR	EIT		V VISEASE	Interval Batween Onset and Death
.O. Box 68	death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 124 No 9 ☐ Unknown		nth 2 ☐ Fetal ant at time of de	death 3	Ectopic pregnancy Other (specify)	′	3.5 0	2	3d. Date of deliv	rery Day Year
<u>α</u>	quires that the signed by	þ	Page II. Other significant conditions	contributing to de	ath but not resu	ulting in the u	A to I A .	en in Part I.				the cause of death?
of Vital Records,	: The law requires that the cate has been signed by the page 2 should be detache	Completed	DIALITE ME MALNUTHING	UINS,	HYPI	SHA	13/01					opsy findings available ompletion of cause of
ion of Vita	Attending Physician: Th r death. ector: Atter this certificate by the funeral director. pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date o (Month		ER/Outpatier 28b. Time or Injury	28c. Injur Wor	4 LI Nursing H		idence 6	Other (Speci	(ty)
Division	i i te	ertification:	3 Suicide 6 Could not determine	d Zoe. Flace	of Injury · At ho	me, farm, str	set, factory, office			Street and wn, State)	Number or Rur	al Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edicai C	29a. Certifying (Check only one)	Physician: To the aminer: On the ba and mann	sis of examinat	wledge, deatl	occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
)	To the within 2 To the comple	W	29b. Signature and title of certifier	Junda	n		29c. Licens	e number 336A		29d. Date	signed (Month,	Day, Year)
R	- (5)		30. Name and address of person wh	DMV S	LOAD,	SUITE	Print)	GAIRIE	MING	, ~	1D: 20	878.
	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 8 2004	32. Re	egistrar's Signa	Local						

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** March 21, FLOYD PHILLIP LANE 2004 9:59P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) OCT • 10,1949 Civista Medical Center Charles 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
N • C • **Funeral №** M 2□F 139-40-7218 54 Yrs **Director** Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ser must be notified at INDIAN HEAD XXYes 2 No CHARLES Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20640 128 CHARLES PLACE U.S.A. Funerai within 72 hours after death 14. Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 M Yes 2 □ No If Yes, Give V I ETNAM Year or Dates: 1 Never Married 2 Married marked other than *natural, or li imatic event, the Medical Examin Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ATLANTIC CITY CEM. 12 CARETAKER other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Pages 1 and 2 should be innent of Health and Mental Health and Mental unknown DOROTHY LANE ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTORIA LANE-SPOUSE 128 CHARLES PL. INDIAN HEAD, MD. 20640 Baltimore, Te II 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) MET = 5 permit. Page Department Important: if any injury or once. METROPOLITAN CREMATORY 3-23-04 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licensee M00479 2. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each in the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** hyson /Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Dualto (or as a consecuence of) dary, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): physician the buria Physician/Medical attending pt for use as ti P.O. Box IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ⊠ es 2 □ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate ha 1 Yes 25 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) uneral dir this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 - Homicide within 24 hours and
To the Funeral Dir To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D-52289 22 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 St Patricks Drive Ste 404 Waldorf, MD 20603 Nalin Mathur, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra MAR 29 200

DHMH 17 Rev 1/2001

LANE

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 6, 2004 **Physician** ALEMAYEHU MULATU 11:30 a^M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 6735 NEW HAMPSHIRE AVE, #607E SPRING SILVER PRINCE GEORGES 8. Date of Birth (Month, Dey, Yeer) 9. Birthplece (State or Foreign Country) 01-28-1955 DEBRE BERHAN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 12 M 2□F 7. Age (In yrs. last birthday) **Funeral** Hours Min. Days 577-29-4791 49 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show Examiner must be notified at 1X Yes 2 No Director MD PRINCE GEORGES SILVER SPRING 10e. Street and Number 10g. Citizen of What Country? 6735 NEW HAMPSHIRE AVE., #607E 20912 ETHIOPIA Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Item 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Un-Known ٩ MIII. ATII WORKIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GIRMA BIRHANE-MESKEL-FRIEND 10043 CHESTNUT WOOD LANE, BURKE, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) TRINITY CATHEDRAL 03-16-2004 DEBRE BERHAN 22. Name and Address of Facility TAYLOR'S FUNERAL HOME 21. Signature of Funeral Service Conspec 1722 NORTH CAPITOL ST., NW WASH. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last burial-t P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the and be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 3□ DOA filled in by the funeral 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who com e of death (Item 23a) (Type, Print) 05 New Hampshire Ave, Takmoph -/4 no, mD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

			1 - For State Ragistrar	State of Ma	ryland / Depa	artment of F	lealth and Death	-, -	109. 140.	104 09	9641
	Dhyaiai		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day	3. Time	of Death
	Physici /Medic		Wilma Constance 1	Myers				March			15 a [™]
	Examin	_	4a. Facility Name (If not institution, give				r Location of Dea	th	4c. County	of Death	
			10461 Waterfowl To			Columb				vard	
l	Funeral Director		216-46-0685	7. Age	(In yrs. last birthday) 95 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		h y, Year) 1908	9. Birthplace (State Country) Maryland	a or Foraign
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside	City Limits
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	28a-	Director	10e. Street and Number		COLUI	10f. Zip Code			10g. Citizen of V	Vhat Country?	
	with Sa or		10461 Waterfowl Te	rraco		210	<i>1</i> , 5		U.S.A.	ŕ	
	na 2	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	· -	Specify Yes or No-		e - American Indian,	
(C)	or Ita	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 N	0			to Rican, etc.)		k, White, etc.	
ğ	raf, c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2ሺ No	Sреспу:		Specify	. White	
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Itema 23e or 28e-1 show Ite Madical Exemires must be motified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of we	orking	16b. Kind of Bu	isiness/Industry	
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	Health tam 27 other tr		20a. Method of Disposition	-C	20b. Place of Dispo	Carlinda		Date		City or Town, State	
lo I	Pages nent of I ant: If Its ary or o		1 ☐ Burial 2 【☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Metropol:	matory`or other plac itan Crem		0/0/	Alexandi	ria, Virg	inia
Baltimore,	교육한 중 .		21. Signature of Funeral Service Licens	1						lome, P.A.	
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100 mg	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	dications that caused one cause on each lin	the death. Do not enter.		ng, such as cardia	c or respiratory ar	rest,	Approxim Interval B Onset ap	Between
	/Medical Examiner		resulting in death)	b. Pue to (or as a	consequence of):	a				6 a	lars
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Oue to (or as a	consequence of):	0 381	bear	disea	80	40	45
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n c	ding P. After t	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor	k?	28d. Describe h	ow injury occurre	ed	
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	To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) Certifying Phy Description of the control of the control of the certifier one)	vsician: To the best of iner: On the basis of and manner state	f my knowledge, deat examination and/or in ted.	h occurred at the tin vestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ourred at the time, o	ause(s) and mar date and place, a	nner as stated. and due to the cause)(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	M		29c. Licens	e number	2	29d. Date signed	(Month, Day, Year)	
	-		Scheefle) (livine	20	(-	3624	6	March	9, 2004	
L	- (3)		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type,	Print) Reaverb	rook K	d. Colo	embia	MD 21	044
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 2 2004	82. Registra	r's Signature						

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Maryl	and / Depa	artmen	t of H	ealth and Death	Mental I	Hygien Reg. N	e 200		0964
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) MINNIE P. MONROE						2. Date of Month MARCI	1 05	200	4	ime of Death
8	Examin Funeral		4a. Fecility Name (If not institution, give s SOUTHERN MARYLANI 5. Social Security Number 6. Sex	HOSPITAL O	CENTER yrs. last birthday)		CLI 1 Year	NTON If Under 24 Hi Hours Mi		f Birth	PRINCE 9. Bit	GEOI	RGES State or Foreign
nat 11:11	Director		265 24 6816 Usuel Residence of Decedent 10a. State 10b. County	M 2XXF	84 Yrs.		Days	TIOUTS IVIII	OCT.			ORIDA	
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24	hours after tural', or Ita	by	1 Never Married 2 Married	1 ☐ Yes ② XNo If Yes, Give Year or Dates:		1 🗆 Yes	XX No	Specify:			Specify: BL	ACK	
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Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 Maurial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)	lemoval from State	NASHINGT	on NA	other plac TION	AL MAR	Date . 11, (04 CI	Location - City o	MD	ate
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1/5 68760, Person	Physician /Medical Examiner partial the price of the pric	dlcai Examiner	Immediate sause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a cor Due to (or as a cor Due to (or as a cor	Av nse of):	kny	De	sease	5N			O.I.S.O	t and Death
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NON R vision of	ling After fune	ation; To	27. Manner of Death 1 Death 1 Death 2 Accident 1 Accident	28a. Date of Injury (Month, Day Yee	28b. Time o		28c. Injur Wor	y at	7		ury occurred	,,	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S)	pecify)				City o	r Town, Sta			e Number,
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CK	(5)		30. Name and address of person who co	ompleted cause of geath	(Item 23a) (Type	, Print)	D	C	INTOI		mp		
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75.2			1 - For State Registrar	State of Ma	aryland		artment of I			Reg		004	09	644
	Physici /Medic		1. Decedent's Name (First, Middle, Las Mildred Lee Mu							Date of Death Month March	Day 6 2	Year 004	3. Time of 3:30	Death P M
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, C	or Location of Thever			4c. County		Georg	ge¹s
	Funeral Director		5. Social Security Number 6. Se		68 (In yrs. la	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day, 1)	^(ear) 1935		ace (State of try) sh., D	
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	th the Ma or 28a-1 s	irecto	Maryland Prince G	eorge s	·		10f. Zip Code	dover	UTTT	10	g. Citizen of \	What Coun		2 NO
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Evantian mark to invilled at ance.	Completed by Funeral Director	3819 - 64th Ave	12. Was Decedent E Armed Forces?		S. 13.	Nas Decedent of I	20784 Hispanic Original, Mexican		y Yes or No- an, etc.)	14. Rac	ited e - Americ ck, White,		í
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Maryland 21215-0036	d be filed antal Hygi ced other cevent, I	Be	12th 17. Father's Name (First, Middle, Last) Edward Floyd			FOC	d Servic			First, Middle, Ma	aiden Suman	10)	CITC	
Maryl	d 2 should the and Me 27 is mark traumati	ပို	19a. Informant's Name/Relationship (7 Diane Gales - Da				g Address (Street			Route Number,	City or Town,	State, Zip		34
	ages 1 and of Heal		20a. Method of Disposition 1 Burial 2 Cremation 3 □	Removal from State	C6	emetery, crer	sition <i>(Name of</i> natory or other pla femorial		Date 2 / 1 2 / 2		oc. Location -	City or To		
Baltimore,	permit. P Departme Importan any injur;		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		That		Name and Address 4001 Ber	ess of Facilit	y Stev	wart Fu	neral	Home		
	Physician		23a. Part I. Enter the disease, or comp shock, or heart failure. List only of Immediate Gause (Final	olications that caused one cause on each lin	Θ.	_	er the mode of dy	ng, such as	cardiac or re	espiratory arres			Approximate Interval Betw Onset and D	veen
	/Medical Examiner		disease or condition resulting in death)	Due to (or as:	0.0	ience of):	LMONAK	16N						
	cuted nd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequ	ence of):								
8760,	ate be executed thysician and the burial-transit	ical	resulting in death) Last	Due to (or as a	a consequ	ence of):								
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	quires that n signed by	by	Part II. Other significant conditions co	ontributing to death bu	ut not resu	ilting in the u	nderlying cause gr	ven in Part I.		23e. Did toba	cco use cont	ribute to th	15.0	eath? Inknown
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Division of Vital	ng Physician: Titer this certifical	on: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 X Inpatie 28a. Date of Injur (Month, Day	v	ER/Outpatier 28b. Time of Injury	T 3LI DOA	her: 4 🗆 Nu	ırsing Home	5 🗀 Residen d. Describe how	ce 6 □Oth)	
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	To the To the compli	Me	29b. Signature and title of certifier			-ME	29c. Licen	se number	82		3 - C			
2			30. Name and address of person who of DONALD GED	completed cause of de	eath (Item	23a) (Type, 3001	Print) HOSPIT	AL B	\varkappa	CHEV	3-9	MD	201	85
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 2 2004	/32. Registra	ar's Signat		L)							

			1- For State of Maryland / Dep	eartment of Health and Nertificate of Death	Mental Hygie _{Reg.}	2001	09645
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Helen McTaggart			Day Year 4 2004	3. Time of Death 12:45 P ^M
	Examir		4a. Facility Name (If not institution, give street and number) Wilson Health Care Center	4b. City, Town, or Location of Death Gaithersburg		4c. County of Death	
Į	Funeral Director		5. Social Security Number 308-07-6862 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 17,	par) 9. Birth Cou 1918 Indi	place (State or Foreign ntry) ana
ylang 21215-0036	uld be filed within 72 hours after death with the Maryland fental Hygiene. rked other then "natural", or Items 23a or 28a-i ehow tic event, it a Madical Examiner must be notified at	To Be Completed by Funeral Director	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	10f. Zip Code 20852 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: edent's Usual Occupation e kind of work done during most of work DO NOT use retired) essor	pecify Yes or No- p Rican, etc.)	Citizen of What Cou United Sta 14. Race - Ameri Black, White, Specify: Wi b. Kind of Business/In	ates can Indian, etc. hite
Baitimore, maryi	permit. Pages 1 and 2 should be Department of Health and Ment Important: If item 27 Is marked eny injury or other traumatic engines.	Te	19a. Informant's Name/Relationship (Type, Print) Margaret C. Claffey / Sister 590 20a. Method of Disposition 1 \(\text{1\text{DBurial}}\) 2 \(\text{DCremation}\) Cremation 3 \(\text{DRemoval from State}\) 1 \(\text{Doqation}\) 5 \(\text{Other (Specify)}\) 21. Signature of Funeral Service Licensee	ing Address (Street and Number or Run 1 Montrose Road #S osition (Name of ematory or other place) Ary Cemetery 2004	Route Number, Cit 5908 Rock Date h 10, Lo eVol Funer	ville, MD Location - City or To	20852 own, State Indiana
8/60,	Examiner Cate be executed Cate by Medical Cate by Medi	dical Examiner	23a. Part 1. Enter the discase, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Highr) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death
O. Box 6	death certiff e attending id for use as	Physician/Mec		□Ectopic pregnancy □ Other (specify)		23d. Date of deliver	ery Day Year
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to to	
II Hecords,	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
DIVISION OF VITAL	yh Sic	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	th (Check only one) ome 5 Residence 28d. Describe how in	nju r y occurred	
N N	To the Hospital or Attending Plyithin 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral	edical Certifi	29a. Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one) 29a Certifier (Check only one)	th occurred at the time, date and place,	28f. Location (Street City or Town, St and due to the cause red at the time, date a	tate) e(s) and manner as s	stated.
1	To the within to the complete	Me	29b. Signature and title of certifier IR heat brusel but he and 30. Name and address of person who completed cause of death (Item 23a) Type of ROBERT BIRSCHE BUTCHERS.	29c. License number 1 50 4/15 1. Print) 2 6 4 1		Date signed (Month, March LLASE BURGA	4,2004
33	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 9 2004 32. Registrar's Signature	Sparket		<i>y</i>	

			riease i	ype or Print in						Legible.	
			For	State of Maryla						2001	00010
			1 State Registrar		Ce	rtificate of	Death	F	leg. No.	2004	09646
	Dhoristat		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medio		MARILYN	1 MCKR	LNN4			MARCH	0:	Ph -	4 8-16-4M
80	Examir		4a. Facility Name (If not institution, give s			4b. City, Town, o	or Location of Death		4c. (County of Deal	th
			Shady Grove Adventi	st Hospital		Rockvil:	Le		Мо	ntgome	rv
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day			thplace (State or Foreign
	Director		194-28-1063	M 2XOF	68 Yrs.	Months Days	TIOUTS IVIIT.	April 2	0, 1	935 Per	nnsylvania
	D _		Usuel Residence of Decedent								
	urylan ahow	_	10a. State 10b. County	10c. 0	City, Town or Lo	ocation					10d. Inside City Limits
	Ba-f	5	New Jersey Bergen	Ric	dgewood						1 X Yes 2 No
	th th or 28	ie	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If time 27 is marked other than "natural; or items 23a or 28a-f show any njury or other traumatic event, the Medical Examine mant be notified at once.	<u>e</u>	35 Ethelbert Place			07450			Unit	ed Stat	tes
	dea dea	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto			4. Race - Ame Black, White	erican Indian,
9	or it	F	1 Never Married 2 Married	1 ☐ Yes 2 ☒No If Yes, Give		1□ Yes 2X No					6, 610.
8	ours ral'.	d by	3 X Widowed 4 Divorced	Year or Dates:		10 103 204110	Specify.			Specify: Wh	nite
ည	72 h natu	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	pation during most of world)	kina	16b. Kin	d of Business/	Industry
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)							
2	ygien er th	Ö		4	Copy (Chief/Edi	tor		Mag	azine	
힏	a Hy foth veni	3e	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	Maiden S	Sumame)	
Maryland 21215-0036	wild b Ment urked utic	2	Norbert Sieber				Mary Tou	itteney			
a	and and		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address (Street	and Number or Rui	ral Route Number	r, City or	Town, State, Z	Zip Code)
Σ	and alth		Elizabeth M. McKenn	a/Daughter	5001	Joshua T	ree Rd.,	N. Potor	mac,	MD 208	378
e e	item item		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other pla				ation - City or	
Ĕ	Page 11 20		1 X Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)		-		·	12. 200	04 r	Moon To	ownship, PA
Baltimore,	nat.	. 4	21. Signature of Funeral Service License		22	2. Name and Addre	ss of Facility Wil	liam F.	Con	rov Fur	eral Home
m	Page 1		Marine	Possel			iers Ave.			-	
			23a, Part1. Enter the sease or complic	cations that caused the de						ii ii ii	Approximate
			shock, or head fallure. Cist only on Immediate Cause Ina.	e cause on each line.							Interval Between Onset and Death
	Pnysician /Medical	Ű	disease or condit in resulting in death)	MYDCA	RIJIAL	- INY	RCTIOI	U			4 DAYS
	Examiner			Due to (or as a conse	equence of):						11 11000
55		_	Sequentially list conditions b	Due to (or as a conse	MAY (CA1.12					1 11173
	pe list	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	540 (5) 45 4 50/150	3 446 11 6 5 017.						
	and and I-trar	хап	that initiated events resulting in death) Last	Due to (or as a conse	aquence of):						
,60	ate be executed hysician and he burial-transit	calE			.,						
	cate phys		d.								
9 ×	The law requires that the death certificate tie has been signed by the attending phy bage 2 should be detached for use as the	Physician/Med	IF FEMALE:	10 H							
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1☐Live birth 2☐Fe	tal death 3	Ectopic pregnancy	/		23	3d. Date of deli Month	very Day Year
0.	at the de by the a tached t	/slc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	death 5L	Other (specify) _					54)
<u>.</u>	d by etacl	Ph)			161 - 1 - 1			an Division			
Ś	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not re	ssuiting in the ui	nderlying cause giv	ren in Part I.	III			the cause of death?
Records,	equi	ted						1 🗆 Ye	es 2-2	No 3 ☐ Pro	obably 4 Unknown
Ö	elawr hasbe je 2sh	Completed						24a. Was a autops		24b. Were au	topsy findings available completion of cause of
Ť	The I	Eo						perform	ned?	death?	2. No
Vital	i ician: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Deat				Ç.E.J 110
>	ysician: is certific director,	o B	examiner?	ospital:	☐ ER/Outpatien	t 3 DOA Oth	er	me 5 Reside		□Other (Spec	cifu)
0	g Phys er this eral di	n: T	27. Manner of Death	28a. Date of Injury	28b. Time of			28d. Describe ho			,/
0	nding P tth. :: After t e funera	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No				
Division of	I or Attendi atter death. Director: A d in by the to	fle	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office				Number or Ru	ral Route Number,
ā	d in I	Certification:	4 Horricide	building, etc. (Spec	ciry)			City or Town	i, State)		
	spita nours nera		29a. Certifier 1 Certifying Physi	icien: To the best of my kr	nowledge, death	occurred at the tir	ne, date and place,	and due to the ca	ause(s) a	nd manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifical completely filled in by the funeral director,	Medical	(Check only 2 Medicel Examin	 er: On the basis of examinand manner stated. 	nation and/or inv	vestigation, in my o	pinion, death occur	red at the time, da	ate and p	lace, and due	to the cause(s)
	omp (#thin	Me	29b. Signature and title of certifier			29c. Licens				signed (Month	
		7	>//WW	FIF F. KURN	14.0 1	10 1	4122	_ 1	INE	W OF	2 2.43.5
	10		30. Name and address of person who cor		m 23a) /Time	Print)	rold T		(-1)/C	. 17 - 7	2001
			ATT PICORUVI		// 1 1 Type.	ROCKULL	F PIKE .	4208	ROCL	Adre	MO 20852
	Sta	to.	31. Date filed (Month, Day, Year)	2. Registrar's Sigr	nature =	a RVICE	1111	12001	w K	.VICE	MO 700)
	Registr		MAR 1 2 200	1 Jenera	9	Sparks					

		•	1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of F			giene Reg. No. 2	004	09647
	Physici	an	1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		Camden Riley					March 8	7		8:45 A M
	Examir	er	4a. Facility Name (If not institution, give				r Location of Dea	th		inty of Death tgomer	57
			Washington Adven 5. Social Security Number 6.5		ITAL Age (In yrs. last birthday	Takoma	If Under 24 Hrs	s. 8. Date of Birt	h		
1	Funeral Director		579-42-7021	1 ∑ M 2□F	78 Yrs.	Months Days	Hours Min		y, Year)		place (State or Foreign ntry) nington, DC
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				Ţ.	10d. Inside City Limits
	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examinational be institled at	tor	Maryland Montgom	ery	Si1	ver Sprin	ıg				1 ☐ Yes 2√ No
	or 284	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cou	ntry?
	23a	al	15100 Interlache	n Dr. Ap		20906				S.A.	
	er dez	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (: an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14.	Race - Ameri Black, White,	
36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	□N°1943-	1 ☐ Yes 2√√ No	Specify:		Spe	ecify: Whi	te
21215-0036	2 hou	ed	15. Decedent's E	ducation	1940 16a. Dece	edent's Usual Occup	pation		16b. Kind o	f Business/In	dustry
215	C * 3	plet	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4c	(Give	kind of work done DO NOT use retired	during most of wo d)	orking	Natio	nal Se	curity
	filed withi Hygiene. other then	Completed		4		alyst			Agen	су	
g	S should be filed within and Mental Hygiene. Is marked other then aumatic event, Ite M	Be	17. Father's Name (First, Middle, Last					me (First, Middle,		name)	
Şla	2 should be f and Mental I Is marked of sumatic eve	ို	Camden Rile			Address (Cassa)		ie Whited		Change Ti	- 0-4-1
Maryland	nd 2 st alth and 27 is n r traun		19a. Informant's Name/Relationship Florence B. McAt			ing Address (Street) Interlac					pring, MD
ē,	s 1 ar		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	ce)	Date	20c. Location	on - City or To	own, State
E	Page nent c int: If		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Speci		Arlington			/2004	Arli:	ngton,	Virginia
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke sny injury or other traumatic once.		21. Signature of Funeral Service Lice	nsee	2	2. Name and Addre	ss of FacilityJos	seph Gawl			
	7		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caus	sed the death. Do not en	ter the mode of dyin	ng, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between
jac.	Physician		Immediate Cause (Final disease or condition	a Severe	eineach	alpos th	n				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):		1 1				
186	Lxammer	_	Sequentially list conditions,	b. Cereb	MOVAS CALV	accid	ent				
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c. Genera	lined of	nero se ler	10019				
,	icate be executed physician and s the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or	as a consequence of):	i i	W / / /				
8760	te be ysicia ie bur	ical		a Dia	betes in	ellitus					
9	rtificat ng phy as th	9	IE EENALE.								
Box	leath certifica attending pt for use as t	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 Live birth		□Ectopic pregnancy	,		23d.	Date of delive	,
.O.	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/M	1 Yes 2 No	4□Pregnant 9□Unknowr		Other (specify)				MORE	Day Year
٩	that the de led by the a detached		Part II. Other significant conditions	contributing to death	n but not resulting in the	underlying cause giv	en in Part I.	23e. Did to	bacco use c	ontribute to t	he cause of death?
ecords,	uires l signé	d by	Cormann arteris	burnes	anott sui	wern		iXv	′es 2 □ No	o 3 ☐ Prot	pably 4 Unknown
Sor	v requ	ete	Santer	L	1.4	1		24a. Was	an 24	th Were auto	ppsy findings available
Re	The law requires ate has been sign page 2 should be	Completed	State State	///				autop perfoi	med?	prior to co death?	mpletion of cause of
Vital		ပိ	25. Was case referred to medical	naunce			26 Place of De	1 ☐ Yes	2 No	1 🗆 Yes	2 No
>		O B	examiner? 1 ☐ Yes 2 No	Hospital:	atient 2 ER/Outpatie	nt 3 DOA Oth	ar	Home 5 Resid		Other (Specif	'v)
οι	ding Phye	n: T	27. Manner of Death	28a. Date of it		of 28c. Injur		28d. Describe h			,,
Ö	Attending or death. sector: After by the fune	atlo	1 Natural 5 Pending 2 Accident investigation	on	,,,,,,		Yes 2 □No				
Division	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined	289. Place of	Injury - At home, farm, s etc. (Specify)	reet, factory, office		28f. Location (S City or Tow	Street and Nu m, State)	mber or Rura	al Route Number,
	pitel		29a. Certifier 1X Certifying P	twelciam: To the be	st ut my knowledge, dea	th consumed as the se	na. date and blan	is and finalization	naunalis and	AND THE RESE	tatori
	e Hos	Medical	(Check only 2 Medical Exa	miner: On the basis and manner	s of examination and/or in	nvestigation, in my o	pinion, death occ	urred at the time, o	date and plac	e, and due to	the cause(s)
-	viffir wiffir To th compl	Me	29b. Signature and title of certifier	2/.		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
,	12		1 Musten	Wen	MY	V20	362		Marci	49.	2004
			30. Na .e and address o person who	completed cause of	of death (Ite a) (Type	Print) Rel	Hya	Tsville	my	20	0782
Ī	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	Spark	2				

			_ FOF	artment of Health and Mertificate of Death		ene g. No. 2 1 1 1	0061.0
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Webster P. Maxson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	March	10, 2004	5:15 A M
	Examin	er	5423 Beech Avenue	Bethesda		Montgome	ry
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthr	place (State or Foreign
×-	Director		013-14-8292		September	24,1916 I11i	nóis
	yland yow		10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	Ba-f si	Director		thesda			1 ☐ Yes 2 No
	with the as or 2	Dire	10e. Street and Number 5423 Beech Avenue	10f. Zip Code 20814		g. Citizen of What Cour United Stat	•
	death	Funeral		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto		14. Race - Americ	can Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show monorant: if item 27 is marked other than "natural", or items 23e or 28e-f show any joury or other traumatic event, the Medical Exant in must be rediffied at ODGS.	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Neuron Never Neuron Never Neuron Never Neuron Never Neuron Never Neuron Neu	1 ☐ Yes 2 No Specify:	Hican, etc.)	Specify: White,	
2	72 ho 'natur	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ing 1	6b. Kind of Business/In	dustry
12	within ane. than	lduu	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) Wyer		Government	
2	Hygie other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name			
/lan	Menta be wild be wirked arked	To B	Harold S. Maxson	Berth	a Kapple		
Maryland 21215-0036	12 sho	1		Charman Transl Dir			- '
	1 and Heatti tem 27		20a. Method of Disposition 20b. Place of Disp	Shawnee Trail, Riv		oc. Location - City or To	
ē	Pages ent of the nt: If ite		Burial 2 XICremation 3 Hemoval from State	Crematorium, Inc. March	$^{13}_{04}$	Bethesda, Ma	aryland
Baltimore,	permit. Departm Imports any inju		21. Signature of Fune 1 Service Licensee Right Months Mol 1305	22. Name and Address of Facility Obert A. Pumphrey Fune 557 Wisconsin Avenue, 1	ral Home/Be	ethesda-Chevy Marvl <i>a</i> nd 2081	Chase, Inc. 4-3501
43			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Carcinoma of Unkn	nown Primary Site			Onset and Death 8 Months
16 5	/Medical Examiner		Due to (or as a consequence of):				
		Jer	S- uentially list conditions, dany, leading to immediate cause. Enter I Indeptying. Due to (or as a consequence of):				
	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
8760,	ate be executed oblysician and the burial-transit	cal E	Due to (or as a consequence of):				
9	ificate g phys as the	edic	d				
Box	eath certific attending pl	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	*
0	The taw requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	1	Other (specify)		Month	Day Year
۵.	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the	ne cause of death?
rds,	w requires been sign should be	ed by			1 🗆 Yes	s 2 No 3 Prob	ably 4 ∑Unknown
eco	e taw requ has been je 2 shouk	Completed			24a. Was an autopsy	prior to coi	psy findings available inpletion of cause of
a B					perform 1 ☐ Yes 2		2 □ No
Ž	Physician: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	26. Place of Death ont 3 DOA Other: 4 Nursing Ho		r) nce 6 ⊡Other <i>(Specif</i>)	٠
1 0	g Physical dispersed dis	n: To	27. Manner of Death 28a. Date of Injury 28b. Time		28d. Describe hov		//
sior	Attending Indeed to death. Sector: After by the funer	catlo	2 Accident investigation	M 1 Yes 2 No			
Division of Vital Record	or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Aura State)	l Route Number,
	To the Hospital or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and place, investigation, in my opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as st te and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
)	1541		· Chub Wa	D29675	М	larch 11, 20	004
	10		30. Name an address of person who completed cause of death (Item 23a) (Type				
	Sta	te.	Ralph V. Boccia, M.D. 6420 Rockledge 31. Date filed (Month, Day, Year) 32. Registrar's Signature	4	ia, Maryl	land 20817	
	Registi		MAR 12 2004 Seneral S	Sporks			

			1 – For State Registrar	State of	Maryland / D	epa Cer	rtment of H	ealth a Death	and Mental	Hygier	ne 200	4 09649
		П	1. Decedent's Name (First, Middle, La	st)					2. Date of Month	f Death	Day Year	3. Time of Death
	Physici /Medio		Muriel Taylor Mac	kav					March		2004	12:30 A M
*	Examir		4a. Fecility Name (If not institution, giv		ber)	ĺ	4b. City, Town, or	Location of	of Death		4c. County of Deat	h
			Wilson Health Car				Gaithers		04112		Montgome	ry
	Funeral		5. Social Security Number 6. S	ex 7 □M 2]X[]F	'. Age (In yrs. last birth 81 Y	rs.	If Under 1 Year Months Days	Hours	Min. 8. Date o	f Birth I, <i>Dey</i> , Yea	9. Birt Co 1922 I11:	hplece (State or Foreign untry)
	Director		579-62-4915 Usual Residence of Decedent		01				July	20,	1922 111	Lnois
	yland		10a. State 10b. County		10c. City, Town	or Loc	cation					10d. Inside City Limits
	a-fal	ctor	Maryland Montgome	ry	Gaithe	ers	burg					tX□Yes 2□No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. (Citizen of What Co	untry?
	ath w		301 Russell Avenu				20877				ted Stat	
	er de Itams	nne	11. Marital Status	Armed Ford		13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Ori n, Mexican	gin? (Specify Yes o , Puerto Rican, etc.	r No-)	14. Race - Ame Black, White	
36	I', or	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Da		1	☐ Yes 2🎇 No	Specify:			Specify: Wh	ite
Š	filed within 72 hours after death with the Maryland Hygiene. uther then "natural", or flams 23a or 28a-1 show ant, the Medical Exeminer must be notified at		15. Decedent's Ed	ducation	16a. I	Deced	ent's Usual Occupa	ition		16b.	Kind of Business/	Industry
2	thin 7	Completed	(Specify only highest gra	Coltege (1-		life. D	kind of work done of OO NOT use retired,	luring mosi)	of working			
7	ed wil	Con		5+	Ноп	nem	aker				n Home	
<u>n</u>	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)						r's Name (First, Mid	ddle, Maid	en Sumame)	
2	Jould Mer Marke Maric	To	Norman W. Taylor	T (D-(-4)	405	6. 6 - 11' -			ldine Ely			
Maryland 21215-0036	d 2 st th and 7 is r traur		19a. Informant's Name/Relationship (• • • •					r or Rural Route Nu			
	1 an Heal tem 2		Norman J. Mackay/ 20a. Method of Disposition	<u> 5011</u>	20b. Place of I	Dispos	ition (Name of		Rocky R		Location - City or	
IO I	A vor		1 Burial 2 Cremation 3		Montgo	mer	atory`or other place	⁹⁾ M	arch 11,		•	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23s or 28s-f show may njury or other traumatic event, the Medical Examiner must be notified at ance.		21. Signature of Funeral Service Licer		Cremato	22.	im, Inc. Name and Addres	s of Facilit	2004 Robert A	. Piim	hesda, M	aryiand neral Home/
ä	Depar Impor any in		ES.	911	M01346	Bei	thesda-Ch	evy (Chase In	c. 75	57 Wisco	neral Home/ nsin Avenue
	T.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ca								Approximate Interval Between
Ŋ.	Physician		tmmediate Cause (Final disease or condition	. (Jement	1	,					Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	r as a consequence of	f):						T (ar)
25	Examine		Sequentially list conditions,	P DOCK			re by	droce	phalus			years
	led sit	ulne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequence of	1):						ě
	and al-trar	Examiner	that initiated events resulting in death) Last	cDue to (o	r as a consequence of	f):						
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d								
9	tificat g phy as th	edi	0									
Вох	eath certific attending p	Physician/Me	IF FEMALE; 23b. Was decedent pregnant		ome of pregnancy	3□	Ectopic pregnancy				23d. Date of deli	-
О. В	e dea he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of death	5 🗆	Other (specify)			-	Month	Day Year
<u>Ч</u>	that the de ed by the a detached t	Phy	9 ☐ Unknown Part II. Other significant conditions of						00. 5			the cause of death?
S,	ires tha signed I be det	by	raitii. Other significant conditions c	onthibuting to dea	itti but not resulting in i	me un	denying cause give	nın Panı.		∏ Yes	_	
Records,	w require been signature	Completed								•		
Rec	has has	шb							a	Va s an utopsy erformed?	prior to c death?	opsy findings available ompletion of cause of
Viita	ician: The l certificate ha rector, page		25. Was case referred to medical					00 Di	1 □ Y∈	s 2 🗗		2 No
>	ysician: is certific director,	o Be	examiner?	Hospital: 1 □ In	patient 2 ER/Outp	atient	3□ DOA Othe	-	of Death (Check or rsing Home 5 F	200	6 DOther (Spec	i6.)
Division of	g Phy er thi	n: T	27. Manner of Death	28a. Date of	Injury 28b. Tir	me of	28c. injury Work				ury occurred	ny)
lor	ath. r: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accidentinvestigation	1	Day reer) Inj	ury		es 2 🗆 N	10			
<u>\S</u>	r Atterder de irecto	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	f Injury - At home, fam g, etc. (Specify)	n, stre	et, factory, office			n (Street a Town, Sta	and Number or Rui	ral Route Number,
	urs af ref D											
	Hosp 24 hor Fune Fune	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exan	niner: On the bas	est of my knowledge, is of examination and/	death or inve	occurred at the time estigation, in my op	e, date and inion, deat	d place, and due to h occurred at the tir	the cause(ne, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	Mec	29b. Signature and title of certifier	and manne	, statou.		29c. License	number		29d. D	ate signed (Month	Day, Year)
	70) At	1) 4	M -		D. 2	01	48	M	P c/225	2004
	\sim		30. Name and address of person who	completed cause	of death (Item 23a) (I	уре, Р	rint)					
			Steven Dul	insky	911 6	V 3	sell Au	re	6 aith	ersbu	rg Mo	
	Sta	-	31. Date filed (Month, Day, Year) MAR 12 20	32. Re	gistrar's Signature	9	South	/				
	Registr	ar	MIWIL TO SE	707			Labor Mark					

			For State Registrar	State of	Marylar		artment rtificate			nd Me	ental Hyg	iene	004	09650
Ī	Physici		Decedent's Name (First, Midd Mary	Kate	٨	/loore		-			Date of Dea Var 21,	th	Yeer	3. Time of Death 11:45 am ^M
	/Medic Examin	-	4a. Facility Name (If not institution Devlin Manor			r	, ,		Location of			4c. Count		
	Funeral Director		5. Social Security Number 251-20-7040	6. Sex 1 □ M 2 □ X	7. Age (In yrs. 80	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Aug 2	5,°1923	9. Birthp	lace (State or Foreign try)
	Maryland f show	tor	Usuel Residence of Decedent 10a. State MD 10b. Count Allie	egany	10c. Ci	ty, Town or Lo	berlar	nd					1	0d. Inside City Limits 1 ☐ 16 2 ☐ No
	3s or 28s-	i Director	10e. Street and Number 10301 Christie	Road NE			10f. Zip		21502	2	1	0g. Citizen of	What Cour	ntry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itams 23a or 28e-1 show aumatic event. The Medical Expresser must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Ma 3 Moowed 4 Divorce		ces? 2 _)(No		Was Deceded of Yes, special Yes 2	V	ispanic Orig in, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	Bla	ce - Americ ck, White,	etc.
Baltimore, Maryland 21215-0036	d within 72 hogiene. or then "natu	Completed	15. Decede (Specify only high: Elementary/Secondary (0-12)	nt's Education est grade completed) College (1-	4or 5+)	(Give	dent's Usual kind of wort DO NOT use make	k done d e retired	ation during most)	of working	7	Own H		dustry
/land	uld be file Mental Hy irked othe	To Be	17. Father's Name (First, Middle John Layne	. Last)								Maiden Sumai on Layn		
, Mary	1 and 2 should I Health and Meni em 27 is marke		19a. Informant's Name/Relation Jamie King	ship (Type, Print)		19b. Mailii P. C	Box	(St <u>re</u> et 2 474	and Number	r or Rural	Paw I	City or Town	, State, Zip	^{Ç⊙de)} WV 25434
imore	Pages nent of int: If it iry or o		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (tate Hil	Place of Dispo cometery, creat ICCEST MC	osition (Naminatory or oti emorial	e of her plac Park	θ)	Da 3	te 3/23/2004	20c. Location Cumb		
l Balt	permit. Pag Department Important: any injury c	0 2. X	21. Signature of Funeral Service	17 Am	lu	4	108	3 Virg	ginia Av	/enue;		land, MD	21502	2
	Physician /Medical Examiner		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cabse (Final disease or condition resulting in death) Sequentially list conditions,	a	2 8	uence of):	/		ccicl	a .	respiratory arr	est,	<	Approximate Interval Between Onset and Death 2 muntus
9,0928	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	r as a conseq				,	4				
O. Box 6	The law requires that the death certifics the has been signed by the attending phage 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta ntat time of d	uldeath 3□	Ectopic pre Other (spe						ite of delive	ory Day Year
0	uires that signed by lid be deta	þ	Part II. Other significant condit	ions contributing to dea	ath but not res	ulting in the u	nderlying ca	use give	en in Part I.			pacco use con	tribute to th	e cause of death?
Division of Vital Records,		Completed									24a. Was a autops perform	ned?	Were autor prior to con death? 1 \(\text{Yes}	osy findings available npletion of cause of 2 No
Vita Vita	Physician: The this certificate har all director, page	Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No	Hospital	patient 2□	ER/Outpatier	2 200	Othe	-		Check only on	1		
ion of	after death. i after death. i Director: After this d in by the funeral di	ation: To	27. Manner of Death Partial 5 Pend 2 Accident inves	28a. Date of (Month tigation		28b. Time o Injury		c. Injury Work		28		ence 6 ⊡Oth ow injury occur		9
Divis	s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	of Injury - At h g, etc. <i>(Specil</i>	ome, farm, str	reet, factory,	office		28	f. Location (St City or Town		er or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To the I l'Examiner: On the ba and mann	sis of examina	owledge, deat ition and/or in	h occurred a vestigation,	t the tim	ie, date and pinion, death	l place, an n occurred	d due to the call at the time, d	ause(s) and ma ate and place,	anner as stand due to	ated. the cause(s)
)	To the within 2 To the complet	2	29b. Signature and title of certifi	1/5					number 766		- 1	9d. Date signe m ムcら	-	•
_	4		30. Name and address of person Vikramaditya	Poonai M.I	_	n 23a) (Type,		24 S	eton [Orive	Cumbe	rland M	ID 215	502
	Sta Registr		31. Date filed (Month, Day, Year	32. Re	gistrar's Signa		Score	87	^					

Montez M. Nol1 Peruary 20, 2004 1:55 at Montez M. Nol1 Peruary 20, 2004 1:55 at Monte String Name (Front institution, pive street and number) 4b, City, Town, or Location or Death Montegomerry 4c, County or Death 4c, County or Death 4c,				State of Marylan 1 - State Registrar	d / Depa	artment of I rtificate of	Health and Me	Copies A ental Hygie	ne 2001	+ 0965
Social Boundary Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Secular Number 25 Secular Numb		/Medi	ical	Montez M. No11 4a. Facility Name (If not institution, give street and number)		1	For Location of Death	Month	28, 2004 4c. County of Dea	th
Specify on the property of t	茶	Director		5. Social Security Number 6. Sex 7. Age (In yrs. 213-09-8147 1 ☐ M 2√2 F 87		If Under 1 Year		Date of Birth (Month, Day, Yeecember	0	thplace (State or Foreign
Security of Security of Business of Part Security of Security of Business Security of Security o		the Maryland 28a-f show	ector	10a. State 10b. County 10c. Cit Maryland Prince Georges Brown		d				10d. Inside City Limits 1,⊠Yes 2 □ No
Specify on the property of t		eath with	eral Dir	4508 37th St,	5 140	2072			USA	
Specify only higher Statistics Specify only higher Statistics		nours after d ural', or Item	Ď	1 Never Married 2 Married 1 Yes 2 St of f Yes, Give		f Yes, specify Cub	an, Mexican, Puerto Ric	y Yes or No- an, etc.)	Black, Whit	e, etc.
Second of the significance of the significan		d within 72 h piene. r than "nate the Meulica	omplete	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. l	kind of work done DO NOT use retire	pation during most of working d)			
20. Memoral of Dispersions 20. Constion - City or Town, Stere 20. Constion - City		ould be filed Mental Hyg arked othe atic event,	Be					irst, Middle, Maid		3verimente
23a. Part : Enter the disease or complications that caused the death. Do not enter the mode of thying, such as cardiac or respiratory arrest, immediate Cause (Final dease or candidate). Approximate interval Development of the cause of the		9 £ 12 5		Ms Cheryl Noll - Daughter 20a. Method of Disposition 1 Marial 2 Cremation 3 Removal from State	4508 lace of Dispo	37th St, sition (Name of natory or other place	Brentwood Date	MD 2072	2 Location - City or	Town, Stete
Physician Medical Examiner		permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee Myslin T. Klebert M01322	22	. Name and Addre	ss of Facility Fort ensburg Rd	Lincoln Brentw	Funera1	Home
Section Sect		/Medical		Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ence of):			rspii atoty arrest,		Interval Between
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. State of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. State of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. State of Injury - At		ine death certifica y the attending phy iched for use as th	yslclan/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 KNo 2 KNo 23c. If yes, outcome of pregnant in the past 12 months? 4 Pregnant at time of de	death 3 🗌					,
25. Was case referred to medical examiner? 1		equires mai en signed t	ted by Pl			derlying cause give	en in Part I.			
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Name and address of person o completed use of death (Item 23a) (Type, Print) Yeheyis Negussie Yeheyis Negussie Yeheyis Negussie Yeheyis Negussie Yeheyis Negussie 29d. Date signed (Month, Day, Year) Yeheyis Negussie 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, D					ia			autopsy performed? 1☐ Yes 2 🔄	prior to co	ompletion of cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Signature and title of certifier 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person o completed use of death (Item 23a) (Type, Print) 1111 Spring/ St., Silver Spring MD 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)	San Dhama	. Atte	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 E 27. Manner of Death 1 Natural 5 Pending (Month, Day Year)	28b. Time of	Work	at 28d.	5 Residence	6 Other (Speci	(y)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45471 March 1, 2004 30. Name and address of person o completed use of death (Item 23a) (Type, Print) 1111 Spring/St, Silver Spring MD Yeheyis Negussie	self or Abbe	urs after de oraf Directo		4 Homicide determined 286. Place of Injury - At hom building, etc. (Specify)				City or Town, Sta	te)	
30. Name and address of person o completed use of death (Item 23a) (Type, Print) 1111 Spring/St, Silver Spring MD D45471 Yeheyis Negussie	4	thin 24 ho the Fune impletely fi	Medica	one) and manner stated.	ledge, death on and/or inve	estigation, in my op	inion, death occurred a	t the time, date a	nd place, and due t	o the cause(s)
1111 Spring St, Silver Spring MD Yeneyis Negussie	F	1 × 8		· Negregon	7	D454				
	-	Sta		1111 Spring St, Silver Spring	MD	Yehe	yis Neguss	ie		

DHMH 17 Rev 1/2001

Moutez M. Noll

		1 - For State Registrar	State o	f Marylan		artment of F				iene	2004	09653
Dhusia	ion	1. Decedent's Neme (First, Middle							2. Date of Deat	h	Year	3. Time of Death
Physic /Med		Anna Gei							March	4,	2004	4:22 PM M
Exami	ner	4a. Fecility Name (If not institution Montgomery Gen				4b. City, Town, or 01ne		of Death		1 .	county of Deetl Montgor	
Funeral		5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth		9. Birth	nplece (State or Foreign
Director		579-07-5559	1□M 2√ F	84	Yrs.	Months Days	Hours	Min.	Month, Day, July 22	, 19	Co	shington, DC
and		Usuel Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
Mary -1 ehc	ţo	Maryland Mont	gomery		Silve	r Spring						1 ☐ Yes 2X No
th the or 288 e notil	lrec	10e. Street and Number				10f. Zip Code			10	0g. Citize	en of What Co	untry?
death with the Maryland ims 23a or 28a-1 show irms Le noullise at	rai	1234 Briggs Ch					905			U	.S.A.	
ter de	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	Armed Fo		.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin, Mexican	gin? (Spec n, Puerto F	cify Yes or No- lican, etc.)	14	I. Race - Amer Black, White	
nours af	þ	3 AWidowed 4 □ Divorced	1/1/ 0'	re		1□Yes 2XNo	Specify:			S	pecify: Wh	nite
should be filed within 72 hours atter and Mental Hygiene. I marked other than "natural", or ite umatic event, the Medical Examire	Completed		t's Education st grade completed)		(Give	dent's Usual Occup- kind of work done	durina most	t of workin	a	16b. Kind	of Business/I	ndustry
within ane. then	mp	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retired	1)			ъ.	1 1 .	10
d be filed intal Hygie ed other	a)	17. Father's Name (First, Middle,	Last)			Execut			(First, Middle, N			g/Construct
uld be Aental rked	To B	George Geiser					Ed	na Ha	ame1			
2 sho and h		19a. Informant's Name/Relations Pauline Geiser		ator	19b. Mailir	ng Address (Street	an <i>d Numb</i> e	or Rural	Route Number,	City or 7	Town, State, Zi	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury prother traumatic event, the Medical Examires must be notified an once.		20a. Method of Disposition				Belgaro	Kd.,					
Separtment of I		1 ∑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State	emetery, crei	matory or other place					ition - City or T	
permit. P Departme importan eny injur		21. Signature of Funeral Service								di F	Tuneral	Maryland Home, Inc.
A B E S S	1	1 July	Disto	2								g, MD 20904
		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that conty one cause on e	aused the deatl	h. Do not ent	er the mode of dying	g, such as	cardiac or	respiratory arre	st,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a	Acut	e r	140 card	101	17/4	rction			Onset and Death
/Medical Examiner		Toolking in County	Due to (őr as a conseq	uence of):	1						7
į.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	uence of).				= 10.			
cate be executed obysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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ficate physics the	edical		d.									
requires that the death certific been signed by the attending f should be detached for use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna		Ti-				230	d. Date of deliv	rery
e deat he atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 No		ant at time of de		Ectopic pregnancy Other (specify)					Month	Day Year
hat the		9 ☐ Unknown >			iting in the w	adoshina sousa avea	n in Bart I		220 Did tob		anatributa ta t	the cause of death?
requires t	d by	artin other signment contain	one contributing to de	100 100	31611g III 019 01	idenying cause give	m m rant.			2 🗆 1		\
s beer	Completed								24a. Was an	2	24b. Were auto	opsy findings available
The la	mo:								autopsy perform	ed?	prior to co death? 1 ☐ Yes	impletion of cause of
ician: The lav certificate has rector, page 2	Be C	25. Was case referred to medical examiner?					26. Place	of Death (Check only one	-	- 10.163	20 140
Physic this or	2	1 ☐ Yes 2 No			ER/Outpatien		4 LI NUI		e 5 ☐ Residen			fy)
ding P. h. After funera	tlon	27. Manner of Death 1 Natural 5 ☐ Pendin 2 ☐ Accident Investig	9	of Injury h, Day Year)	28b. Time of Injury	28c. Injury Work M 1 □ Y	at :? ∕es 2 □ N	1	ld. Describe how	v injury o	ccurred	
Atten r deal ector: by the	Certification:	2 Accident investig 3 Suicide 6 Could in 4 Homicide determine	act ho	of Injury - At ho	me, farm, str	set, factory, office			f. Location (Stre	et and N	lumber or Rura	al Route Number,
tal or	Cert	4 Nomicide	buildir	ig, etc. (Specify	<i>'</i>)				City or Town,	State)		0
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	(Check only 2 Medical	g Physician: To the Examiner: On the ba	sis of examinat	wiedge, death tion and/or inv	occurred at the tim restigation, in my op	e, date and inion, death	d place, an	d due to the cau	use(s) an	d manner as s	stated. o the cause(s)
thin 2 of the of the of the ormplet	Med	one) 29b. Signature and title of certifie	and mann	er stated.		29c. License					igned (Month,	
F > F 0		> (Illet 1864	1	Phys	1619			5694				4,2004
13		30. Name and address of person	who completed cause	of death (Item	23a) (Type	Print\						
			THUR			- Ley toisvil	11c 12	U	Olsey,	MD	2083	۷
Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 08		gistrar's Signal	ture &	Sparks	1					
		HILLI O O	-VV1		/	//						

			1 - State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H rtificate of	lealth and <i>Death</i>	Mental Hy	giene 2	004	09654
	Dhootel		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		CATHERINE	DEE	NOR	TH		March	3 20	04	2:58 P M
	Examin	er	4a. Facility Name (If not institution, give s HOLY CROSS HOSPI				Location of Dea			inty of Death	
			5. Social Security Number 6. Sex		e (In yrs. last birthday)	JILVE	R SPRING			NTGOME 9. Birth	Place (State or Foreign
*	Funeral Director			M 2 🗷 F	62 Yrs.	Months Days	Hours Min		7, Year) 1941	Сои	Utah
	P		Usual Residence of Decedent 10a. State 10b. County		100 City Town sale						
	shov	j.	Md. Montgo	merv	10c. City, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	Director	10e. Street and Number		0111	10f. Zip Code			10g. Citizen	of What Cou	
	3a or	Ī	1 Old Baltimore	Court			20832			ted St	•
	death	Funerai	11. Marital Status	2. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Specify Yes or No-	14. F	Race - Ameri Black, White	ican Indian,
36	or It	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 N	No i	1 □ Yes 2 No	Specity:	,	1	ocify:	White
21215-0036	be filed within 72 hours after death with the Maryland hat hygiene. d other than "natural", or itema 23e or 28e-f show event. The Madical Exist itself result for indifficial at	ed b	15. Decedent's Educ	Year or Dates:	16a. Dece	ient's Usual Occup	ation	1	16b Kind o	f Business/Ir	ndustov
215	hin 72 in "na Medic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of work done OO NOT use retired	during most of wo	orking		, , , , , , , , , , , , , , , , , , , ,	
	giene giene er the	EoC	12	3		rse			Н	ospita	a1
Maryland	be file	Be	17. Father's Name (First, Middle, Last)	•				me (First, Middle,		name)	
2	should ind Men ind Men ind marke	ဥ	James Patrick 19a. Informant's Name/Relationship (Type	Greaney		g Address (Street	Ela		ndlay	Ctata Ti	- Codel
Z	and 2 signal and 2 signal and 27 is read in a traum		Gary J. North /			Old Balt					20832
re,	thea Item		20a. Method of Disposition		20b. Place of Dispo	sition (Name of natory or other place	(e)	Date	20c. Locatio	on - City or To	own, State
Ш	Pages nent of h ant: If Ite		1 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Gate of H			12/04	Silve	r Spri	ing, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydrene. Importants: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event. In a Medical Exact instituted at once.		21. Signature of Funeral Service License	Bary	Res 22	Name and Addre Muriel P. O.	ss of Facility H. Barbe	r Funera Layton	l Home	Md	20882
ß	45		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused	the death. Do not ente					, 11a.	Approximate Interval Between
3	Pnysician) p	Immediate Cause (Final disease or condition		tic ovari					11	Onset and Death 1 Months
X 5	/Medical Examiner		resulting in death)		a consequence of):		-				1100000
Š.	n Age	7	Sequentially list conditions,		a consequence of):						
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease Orinipaly that initiated events	(
oʻ	cate be executed physician and the burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate be nysicia he bu	dicai	d								
9	ertifica ling pl	Med	IF FEMALE:								
Вох	The law requires that the death certific ate has been signed by the attending to page 2 should be detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	ery Day Year
o	that the de ed by the detached	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□ Unknown	time or death 5	Other (specify)					
<u>α</u>	signed b	by PI	Part II. Other significant conditions con	tributing to death be	ut not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use co	ontribute to t	he cause of death?
rd	v requires been sign should be							1 🗆 Y	es 2 No	3 ☐ Prot	bably 4 DUnknown
Vital Records,	law ri las be	Completed						24a. Was a autop	sy	prior to co	ppsy findings available impletion of cause of
<u> </u>		Con						perfór 1 ☐ Yes	med? 2 XNo	death?	2 No
Zi Zi	yaician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner?	ospital:		t 3 DOA Oth	oc .	ath (Check only or			
ō		-	1 ☐ Yes 2 No 27. Manner of Death	1 Mnpatie 28a. Date of Injur	y 28b. Time of	28c. Injur	+ □ Nursing F	dome 5 ☐ Resid			(y)
ion	Attending Ph or death. octor: After th by the funeral	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	/ Year) Injury	M 1 🗆	k? Yes 2 □ No				
Division of	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, stre	et, factory, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	al Route Number,
	Hospital or Attence to hours after death Funeral Director: tely filled in by the to		20 0 11 20 20 20 20								
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 ☐ Medical Examin	er: On the basis of and manner sta	of my knowledge, death examination and/or invited.	occurred at the ting restigation, in my o	ne, date and place pinion, death occi	e, and due to the our urred at the time, o	ause(s) and late and plac	manner as si e, and due to	stated. the cause(s)
	To the To the Comp	Ň	29b. Signature and title of certifier			29c. Licens	e number	2	29d. Date sig		
•	7		Paul Barren			MD	006033	5	MAR	CH 9,	2004
	`		30. Name and address of person who con		eath (Item 23a) (Type, I		DBINE #	327 01	NEY, M	ID 21	0832
	Sta	te	PAUL BANNEN, M.D. 31. Date filed (Month, Day, Year)	32. Registra	ar's Signature			027, UL	11 - 11	D. 41	
ЭX	Registr		MAR 1 0 200	14 June	wa B	Spark					

			1 - For State Registrar	State of	Marylar		artment of rtificate o				ene 20	04	0965
			Decedent's Name (First, Middle	ie, Last)						Date of Death	1	3.	Time of Death
	Physici /Medio		Swee Keng Ng							Month Iarch		ear	9:15 PM
	Examin		4a. Facility Name (If not institution		iber)		4b. City, Town	n, or Location			4c. County of		
			Montgomery G					ney			Montg	omery	
	Funeral		5. Social Security Number	6. Sex 1		last birthday) Yrs.	If Under 1 Yes Months Day		Min.	Date of Birth Month, Day,	Year)	Country)	(State or Foreign
	Director		212-66-4162 Usual Residence of Decedent		80) 115.			Au	ıg. 12,	1923 1	4a1ays	ia
	yland Now		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation		· · · · · ·		-	10d. Ir	nside City Limits
	Mar.	tor	Maryland Monte	gomery	Е	Brookev	ille					1	□Yes 2∏No
	or 284	Directo	10e. Street and Number	,			10f. Zip Code	9		10	g. Citizen of Wh	at Country?	
	23a		2512 Sapling	Ridge Lane	2		2083	33			USA		
	tams	Funerai	11. Marital Status	12. Was Deced Armed For		J.S. 13.	Was Decedent of f Yes, specify Co	f Hispanic Ori	igin? (Specify n, Puerto Ricar	Yes or No- n, etc.)		American In White, etc.	dian,
9	be filed within 72 hours after death with the Maryland that Hyghene od other than "natural", or Itams 23s or 28s-f show event, the Medical Exprinter must be notified at	by F	1 ☐ Never Married 2 🔀 Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	9		1 ☐ Yes 2 ☒ N	lo Specify:			Specify: [
9500-61212	hour tural	ed k		Year or Da	1165:	16a Decer	ient's Usual Occ	cupation		1.1			
Č	n "ne	Completed	(Specify only highe	st grade completed)	46.1	(Give	kind of work dor DO NOT use reti	ne durina mosi	t of working	1	6b. Kind of Busir	iess/industry	/
7 7	d with giene	mo:	Elementary/Secondary (0-12)	College (1-	40r 5+)	Wa	itress				Food	Servi	ce
ğ	be filed within 72 at Hygiene. Ind other than "natewent, the Wede.	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (Firs	st, Middle, M	aiden Sumame)		00
yiand	should by and Menta	To	Unknown 1	lap					Heng N	lak			
Mar	and and the ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Stre	et and Numbe	er or Rural Rou	ite Number,	City or Town, Sta	te, Zip Code	9)
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic events.		Chew Fong Ng	Husband	1	2512	Sapling				eville,		
saitimore,	If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 🗀 Removal from S	tate - C	cemetery, cren	sition (Name of natory or other p	nlace) M	arch 13	3,	Oc. Location - Cit	y or Town, S	state
	rtant:		*4 □ Donation 5 ☑ Other (S		nt Gai	te of H Cemete	ry		2004	S	ilver Sp	ring,	MD
<u>a</u>	Dermi Depa Impo eny i		21. Signature of Funeral Service	Licensee		Fr	Name and Add ancis J	. Colli	Íns Fun	eral H	Home Inc		
	w. 80		23a, Part 1, Enter the disease, or	complications that ca	used he deat	50	U Unive	rsity F	Blvd. W	. S11	ver Spr	ing, M	D 20901 roximate
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final						Cardiac or resp	pliatory arres	, ,	Inter	val Between et and Death
	Physician /Medical		disease or condition resulting in death)		Respi:		Failure	<u> </u>		·			
	Examiner			b. Septi		1401100 017.							
Ш		ner	Sequentially list conditions, if any, leading to intrinduction cause. Enter Underlying		r as a conseq	juence of).							
	ecuter ind trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last				lar Acc	ident					
8/00,	cate be executed physicien and the burial-transit		resulting in death, case	· ·	r as a conseq	,							
	icate be executed physicien and s the burial-transit	dicai		d. Hyper	tension	n							
D X O	ie law requires that the death certific has been signed by the attending f ge 2 should be detached for use as	ician/Me	IF FEMALE:	23c. If yes, outco	ome of pregna	ancv				_ 33dy.			
Ď	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live bir	th 2 Feta	l death 3	Ectopic pregnan Other (specify)	псу			23d. Date of Month	Day	Year
j.	the cachec	Physi	9 Unknown	9□ Unknov									
Ž.	The law requires that the ate has been signed by the page 2 should be detached.	by P	Part II. Other significant condition	ns contributing to dea	ath but not res	ulting in the un	derlying cause g	jiven in Part I.	2	3e. Did toba	cco use contribu	te to the cau	se of death?
ğ	equire en sig	edk	Breast Cancer,	Congestive	e Heart	t Failu	re,			1 🗀 Yes	2□No 3[Probably	4 ☑Unknown
ecords,	law re as be 2 sho	Completed	Non-Insulin De	pendent D	iabete	s Mell:	itus		2	4a. Was an	24b. Wer	autopsy fin	ndings available
Ľ	The ate har page	Com							1	autopsy performe ☐ Yes 2 2	id? deat	to completio h? Yes 2∐ N	on of cause of
	tending Physician: The isath. for: After this certificate he the tuneral director, page	Be (25. Was case referred to medical examiner?					26. Place	of Death (Che				
5	hysic this cu	2	1 ☐ Yes 2 ☑ No			ER/Outpatient	JUDON		rsing Home	5 🗌 Residend	ce 6 Other (Specify)	
	ing P	on:	27. Manner of Death 1 ⊠Natural 5 ☐ Pendin		Injury Day Year)	28b. Time of Injury	28c. Inj			escribe how	injury occurred		
2	offer displaying the top	cat	2 Accident investig	not be	A letter A A E e			TYes 2□N					
JIVISION	or Att after d Direct in by	Certification;	4 ☐ Homicide determ	ined 28e. Place o	g, etc. (Specify	y) arm, stre	et, factory, office	9		ity or Town, S	et and Number o State)	r Rural Rout	e Number,
	To the Hospital or Attending within 24 hours after death. To the Funaral Director: Attercompletely filled in by the tune		29a. Certifier 1[X Certifyin	g Physician: To the b	est of my kno	wledge death	occurred at the	time date and	I place and di	in to the cau	co/o) and manna	r on stated	
	e Hos	edical	(Check only 2 Medical one)	Examiner: On the bas and manne	sis of <u>e</u> xamina	tion and/or inv	estigation, in my	opinion, death	h occurred at t	he time, date	and place, and	due to the ca	ause(s)
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	Me	29b. Signature and title of certified		()	0	29c. Licer	nse number		29d	. Date signed (M	onth, Day, Y	'ear)
			> 1 Wh		16	wal) Ď4	5391			March 5,	2004	
	V		30. Name and address of person	who completed cause	of death (Item	1 23a) (Type-F	rint)						
			Chukwuemek Nwo				y Drive,	, Gaith	ersbur	g, MD	20879		
	Star Registra	_	31. Date filed (Month, Day, Year) MAR 0 9	2004 32. Reg	gistrar's Signa	ture	Sound	21					

04-1744 AKG		1 - For State Registrer	State of Maryland	d / Depa		lealth and N	Mental Hygi	ene 2004	09656
		Negistrar Necedent's Name (First, Middle, Last))		timodito or	Douth	2. Date of Death	g. 140.	3. Time of Death
Physici		Angeline The	resa Nicro				Month March	Day Yeer 3, 2004	2235 P ^M
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death	11012 011	4c. County of Death	
		Holy Cross Hospit	al		Silver	Spring		Montgame	erv
Funeral		Social Security Number 6. Se	TM 2187 E		If Under 1 Year Months Days		8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign intry)
Director		5//-32-/662	76	Yrs.			Sept. 20	, 1927 Wash	nington, DC
land w		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Mary -1 sho	টু	Maryland Montgon	ierv	Roc	kville				1 ☐ Yes 2 ☒ No
r 28a	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
th will	aD	11403 Grayling Lar	ıe		208	52		USA	
ams ams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
or it		1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify: Wh1	
be filed within 72 hours after death with the Maryland all hygiene. It hygiene do the than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	d by	3 XWidowed 4 □ Divorced 15. Decedent's Edu	Year or Dates:	16a Dagar	dent's Usual Occup	ation	1 44		
in 72	Completed	(Specify only highest grad	e completed)	(Give	kind of work done i DO NOT use retired	ation during most of work d)	ring	6b. Kind of Business/Ir	•
with iene ther	E O	Elementary/Secondary (0-12)	College (1-4or 5+)			ve Assist	2	Food and D: Administ:	0
Hyg other	a)	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma		acton
Id be denta	To B	Giuseppe Giacinto)		0.00	Salvat	rice Brud	ccoleri	
al y allo Z 1 Z 1 Z 1 Z 1 Z 1 Z 1 Z 1 Z 1 Z 1 Z		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailin	g Address (Street	and Number or Rur	al Route Number, (City or Town, State, Zij	Code)
and 2 and 2 salth a n 27 is		Teresa A. Baughman				Cane Lane	, Gaither	rsburg, MD	20882
D - 1 5 5		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. Pla	ace of Dispo metery, crem	sition (Name of natory or other place e K	(e) Marc	Date 20 h 15,	Dc. Location - City or T	own, State
mit. Pages partment of I portant: If its y injury or o		'4 □Donation 5 □ Other (Specify)	ROC	Cemet	ek ery	200		ashington,	DC
Danit permit Depart Import any in		21. Signature of Funeral Service Licens	Parker	Fr	Name and Address	Collins	Funeral H	Home Inc.	
		+TIPL MUITE	_ / 04	50	<u>O Univer</u>	sity Blvd	. W., Sil	lver Spring	MD_20901
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ne cause on each line.	. Do not enti	ALA	19.	or respiratory arres	τ,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Chest	and	Masn	ynel -	comun	હ	
Examiner			Due to (or as a consequent	ence of):			,		
	e.	Sequentially list conditions,	o. Due to (or as a consequ	anna uf):					
uted I Insit	m L	Sequentially list conditions, as y, leading to in rediate cause. Enter Underlying Cause (Disease or injury that initiated events							
be executed rician and buriat-transit	Examiner	resulting in death) Last	Due to (or as a consequent	ence of):					
w requires that the death certificate be executed wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	cal		J						
diffication of physical as the	Medi	IC CCIMIC				22312301			
th cei	Physician/Med	230. was decedent pregnant	3c. If yes, outcome of pregnan 1 Live birth 2 ☐ Fetal		Ectopic pregnancy			23d. Date of deliv	
e dea he at	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of de. 9☐ Unknown		Other (specify)			Month	Day Year
at the day t	Phy	9 Unknown)							
The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by	Part II. Other significant conditions con	ithouting to death but not resul	iting in the ur	iderlying cause givi	en in Part I.		cco use contribute to t 2 No 3 □ Prot	ne cause of death?
requires requires been signature bould be	eted						1 Tes	2 A NO 3 F F 101	Jabiy 4 Donknown
2 g g d	ompleted						24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
VICAL DECIDION STREET THE LANGUAGE PASS (PECTOR), PAGE 2	O								2 □ No
Attanding Physician: sr death. ector: Atter this certification the funeral director, is	Be	25. Was case referred to medical examiner?	lospital:		2CI DOA Othi	Ar	n (Check only one)		
Phys rat di	. To	1XXes 2 No '	1 ∐ Inpatient 24 XE	R/Outpatien 28b. Time of	1 3 DOA	4 Nursing no	me 5 Residence 28d. Describe how	be 6 ☐Other (Specif	(y)
th. : Afte	tlor	1 ☐ Natural 5 ☐ Pending 2 ☐ Ccident investigation	(Month, Oay Year)	Injury	Worl ZM 1□	K?	ascence	- mait	Com isle +
Attan dea octor	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ne, farm, stre	,		28f. Location (Stree	et and Number or Rura	Il Route Number,
after d in t	ert	4 Homicide determined	building, etc. (Specify)	TREZ	-	1	City or Town,		e (4)
spita hours inere		29a. Certifier 1 Certifying Phys	sician: To the best of my know	vledge, death	occurred at the tim	ne, date and place,	and due to the caus	se(s and manner as s	tated. Rockville
To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Exami	ner: On the basis of examination and manner stated.	on and/or inv	estigation, in my of	pinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
Vithii To 11	ž	29b. Signature and title /f certifier/	. 0		29c. License	number	29d	. Date signed (Month,	Day, Year)
10		Vetorhe	my)		0.0	M.E.	Ma	rch 10, 20	004
		30. Name and address of person who co	impleted cause of death (Item	23a) (Type, I			, (10		
		J. HRON U	sect, My		111 Pe	enn Stree	t, Baltim	ore, Maryl	and 21201
Sta Registr		31. Date filed (Month, Day, Year) MAR 11 200	32. Registrar's Signatu	LIFE LG	Sparks				
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State of Maryland / Department of Health and Mental Hygiene 2001. 09657 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** March 9, 2004 Vivian Patricia O'Brien 6:10 A.M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Crofton Convalescent Center Anne Arundel Crofton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☐ XF 579-10-3673 Yrs 17.1917 Director Wash Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28e-f show 1 ▼ Yes 2 No Director Prince Georges Bowie the 10g. Citizen of What Country? 10f. Żip Code 10e, Street and Number USA 4011 Nicholas Place 20716 Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Electric Utility 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Susan Greer Theodore Cameron 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4011 Nicholas Place, Bowie, Md. 20716 Nancy M. Cain-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition $03 - 13^{\text{de}} - 04$ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Md. permit. Page Department of Importent: If any injury or once. Ft. Lincoln Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S ce lights 22. Name and Address of Facility Beall Funeral Home 20715 6512 N.W. Crain Hwy., Bowie, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnan 3 Ectopic pregnancy Day ò in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed page 2 No 1 Yes 1□ Yes 20 or Attending Physician: certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner a Geath 28b. Time of After 1 Matural 5 Pending Within 24 hours after deam.

To the Funerel Director: Aft 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 11- certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 052139 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blvd. Suite 200 2401 Brandermill MATTO SETAL 31. Date filed (Month, Day, Year, Registrar's Signature State MAR 1 0 Registrar

		1 - For Stete Registrar	State of Maryla	nd / Depa	artmen rtificate	t of H e of L	lealth ar Death	nd M	lental Hy	/giene Reg. No		04	0965
		1. Decedent's Name (First, Middle, Las	st)						2. Date of De	eath Da	v	Year	3. Time of Death
Physicia /Medic		Elsie Natalie Ot	stot						March		2004	1001	2:15 a M
Examin	-	4a. Facility Name (If not institution, give	e street and number)		4b. City,	Town, or	Location of	Death		4c.	. County	of Death	
n .		Sacred Heart Num				ttsv 1 Year	ille If Under 24	4 Hec					rge's
Funeral Director		563-03-4868	ex 7. Age (in y/s	() Ast birthday)	Months	Days		Min.	8. Date of Bi (Month, D. Aug • 2	28, 1	903	Swed	lace (State or Foreigr try) den
and and	}	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation							1	0d. Inside City Limits
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. Other 27 is marked other than "natural", or Itema 23a or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at	Į.	Maryland Prince	George's H	yattsvi	111e								1 X Yes 2 □ No
r 28a	Directo	10e. Street and Number		, 4000	10f. Zip	Code				10g. Cit	izen of W	hat Coun	itry?
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ema arm	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	J.S. 13.	Was Deced	ent of Hi	ispanic Origir n. Mexican. I	n? (Spe	ecify Yes or No Rican, etc.)	0-		- Americ	an Indian,
a de la		1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes							Whi	
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ant, l	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	s Name	(First, Middle	, Maiden	Sumame	9)	
ked ic av	To B	Andrew Johnson					Hu1d	a A	nderson	n			
s ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address	(Street a	and Number	or Rura	/ Route Numb	per, City o	r Town, S	State, Zip	Code)
or tra		Margery Chaney -	- Niece	7215	Winds	sor 1	Lane,	Hya	ttsvil	le, N	ary1	and	20782
r oth		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐		Place of Dispo cemetery, crea	sition (Nam matory or o	ne of ther plac	a)	D	ate	20c. Lo	ocation - 0	City or To	wn, State
ant: I		`4 □Donation 5 □Other (Specific	Me:	tropoli									Virginia
Important: If ite any injury or ot once.		21. Signature of Funeral Service Licer	1500						ch's Fu				
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for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	Ectopic pro						23d. Date Mon	of delive	ry Day Year
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page 2	Completed								auto	psy ormed?	pr de	ior to con eath?	npletion of cause of 2 No
is certificate director, pag	Be	25. Was case referred to medical examiner?						f Death	(Check only	one)			
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Atter	ertiflcation;	27. Manner of Death 1 图Natural 5 Pending 2 Accident investigation		28b. Time of Injury	M 21	Bc. Injury Work	at :? ∕es 2 □ No		28d. Describe	how injur	y occurre	d	
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e Funeral L letely filled	edical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred a vestigation,	at the tim	e, date and printed in the determinant of the deter	place, a	and due to the ed at the time,	cause(s) date and	and man place, ar	ner as stand due to	ated. the cause(s)
To the Complet	Me	29b. Signature and title of certifier	^		29c	License	number			29d. Dat	e signed	(Month, E	Day, Year)
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)		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type,	Print)								
/		Bahram Pishdad,		ıthern	Avenu	e, S	E, Was	shin	igton,	DC 2	0032		
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		1 - For State Registrar AMEND#25perMD3 1. Decedent's Name (First, Middle, Last,	/9/2004,BMW,	ryland / Dep McCo Ce	artmen rtificat				•	Reg. No. 2	004	09650
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Funeral Director		5. Social Security Number	7. Age	(In wrs. last birthday) Yrs.	If Under Months	-	If Under 2 Hours	Min.	8. Date of Bir (Month, Da July I			place (State or Foreign ntry) aska
he Maryland 8a-f show	ector	MD 10b. County Anne Ar	undel	10c. City, Town or Lo Annapol	is							10d. Inside City Limits
h with t	ai Dir	10e. Street and Number 3208 River Cresc	ent Drive		10f. Zip	2140	1			10g. Citizen d	S.A.	ntry?
Lary failed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28s-f show eumatic event, the Medical Exant ret must be coulified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 2 3 N If Yes, Give Year or Dates:	0	Was Deced If Yes, spec		spanic Origi n, Mexican, Specify:	in? (Spec Puerto R	cify Yes or No lican, etc.)	8	Race - Ameri Black, White, city: Wh.	etc.
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	Funeral Director		5. Social Security Number 6. 3 268-18-4504	ex 7. Ag	e (In yrs. I 83	ast birthday, Yrs.	If Under Months		Hours Min.	8. Date of Birt (Month, Da May 7,	1920	9. Birthi Cou Ge	olace (State or Fo ntry) rmany	oreign
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To #	within To 11	Ž	29b. Signature and tifle of certifier	/			29	c. License	number	- 7	29d. Date sig	ned (Month.	Day, Year)	
			Marine The					DS	518	T	3/	18/	04	
	K		30. Name and address of person who	completed cause of	death (Item	23a) (Type	, Print)		٨	1	14		0	V
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State of Maryland / Department of Health and Mental Hygiene 200 l 09661 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month
February 113 County of Death **Physician** Ethel Parker 41.25AM 29,2004 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bladens burg _ogan Way Prince Georges If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 579-54-0279 1□M 2XF Months Days Yrs. Director le Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Bladensburg Funeral Director 1. Yes 2 □ No Georges 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 15A 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo If Yes, Give Year or Detes: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health end Mantal Hygiene. Important: If Itam 27 is marked other than "naturel". or heary injury or other traumatic events. Black, White, etc. 1 Never Married 2 Married 1□ Yes 2 No Specify: þ 3 Widowed 4 □ Divorcad Black Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) aundry reamtress 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be curres Lowler Willie Mae Wilburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 3203 Walters Lane # 204 District Heights MD 20747 ranker 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🕱 Cremation 3 ☐ Removal from State Metropolitan Crematory 3/8/04 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility Greene Funeral Home 814 Franklin Street, Alexandria, VA 22314 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical CANdis Unsendow Iteast D Examiner Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completely fillad in by the funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Dinb etes 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examine? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) edical Certification: To 1 Yes 2 No 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 150055927 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) SALVADON 3001 31. Dete filed (Month, Day, Year) 2. Registrar's Signature State MAR 0 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend Items 7,8 per 11 9845 7–16–05 vt.

State of Maryland / Department of Health and Mental Hygiene 2004

09662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:30am Bernice Pau1 /Medical February 27,2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Thomas Moor Prince Georges Co. If Under 24 Hrs. 8. Date 3 Bitto 28 (Month, Day, real) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 M 2 F Unknown 75rrs. Months Days Hours Washington, DC Director 578-34-7841 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f sho traumstic evant, the Medical Examera must be notified at Hvattesville Prince Georges MD Director Y☐ Yes 2☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 U.S.A. 4922 Lasalle Road Funeral Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 ☐ Married 1 ☐ Yes Ž ☐ No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: B1ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) Unknown Unknown permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygient Important: If item 27 is marked other that any injury or other traumstin any injury or other traumstin any injury or other traumstin any injury or other traumstin any injury or other traumstin any injury or other traumstin any injury or other traumstin any injury or other traumstin and injury or other traumstin an Unknown Unknown Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3192 Westover Dr. SE Washington, DC 20020 19a. Informant's Name/Relationship (Type, Print) Kimberly Edley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2☐Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk Crematory 3/13/04Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy St. NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused tile death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List thily one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Hypertensive Caediovascular Disease Examiner Due to (or as a consequence of) Physician/Medical Examiner Coronary Athrosclerotic Disease or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No Progresive Cognitive Decline 3 ☐ Probabiy 4 ☐ Unknown signed b <u>۾</u> Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Degenerative Joint Disease has Ž□ No 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending after death.

Director: Aft
d in by the fu investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD21524 March 4, 2004 who completed cause of death (Item 23a) (Type, Print) .C. 200181 ti 31. Date 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

3 enice

CELERINO PITPIT 04 - 1511UNKNOWN 04-055 B.K.S

Pages 1 and 2 should be filed within 72 hours after death

f Health and Mental Hygiene.

jo #

and

attending physician

signed

peeu

certificate

After

death.

To the Hospits! o within 24 hours aft To the Funeral Di

after death

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 0 0 L Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day FEBRUARY 28, **Physician** Celerino Batugo Pitpit 2004 2147 P^{M} /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BERLIN Examiner ATLANTIC GENERAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Feb 3, 5. Social Security Number 9. Birthplace (State or Foreign Country) Philippines 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 53 Director 03-2169364-6 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f shov other trsumatic event, the Medical Examinar must be notified at 1√E¥es 2 □ No Director Philippines Caloocan City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 150 Marulas A 1400 Philippines Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 1 Yes 2000 Specify Specify Filipino 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2+ Seafarer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Liborio Ancheta Pitpit Gregoria Marcelino Batugo ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angelina B. Pitpit (wife) 150 Marulas A., Caloocan City, Philippines 1400 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö 1 Burial 2 Cremation 3XX emoval from State permit. Page Department of Important: If ony injury or La Loma Cemetery 3/20/2004 Caloocan City Philippin * 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of FacilityMetropolitan Funeral Service 122 East Berkley Avenue, Norfolk VA 23523 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HSSOC. /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 99 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient XXDOA filled in by the funeral 28c. Injury at Work? 27. Manner of Death 1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Ship sank 1930 HKI Yes 2 □ No 27/04 6 Could not be determined 28f. Location (Street and Number of Rural Route Number, City or Jown, State) Atlantic Office to ranked miles from Assorbed see Island Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Ocean Virgin 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E FEBRUARY 29, 2004 30. Name and address of person who completed cause of eath (Item 23a) (Type, Print)

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

THEODOREM. KING 31. Date filed (Month, Day, Year) -State MAR 1 1 2004 Registrar

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H rtificate of I			iene 20 ()4	09664
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dear Month	Day	Year	3. Time of Death
Е	/Medic	al	Anna Pros		r1	4b. City, Town, or	Logation of Do	March 1	4c. County of	of Dooth	5:45A [™]
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	Funeral		5. Social Security Number 6. Sex	7. A	age (In yrs. last birthday)	If Under 1 Year	If Under 24 H	S. 8. Date of Birth		9. Birthplac	e (State or Foreign
	Director		032-09-3255]M 2□XF	91 Yrs.	Months Days	Hours Mi	May 8,	1912	New Y	ork
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d	. Inside City Limits
	Maryl f sho	tor	Maryland Montgo	merv	Bethe	sda					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number	J. C. C. C. C. C. C. C. C. C. C. C. C. C.		10f. Zip Code		1	0g. Citizen of W	hat Country	/?
	th wit		4925 Battery Lar	ne, Apart	tment 205	208	14	1	U.S.A.		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other then "neturel", or items 23e or 28a-f show aumatic event, the Mariles Exertimetral the Intiffied at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ∑ If Yes, Give Year or Dates	(No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origin? in, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)	Black	- American , White, etc Whit	S
Maryland 21215-0036	2 hou	ted t	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bus	siness/Indus	stry
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<u>6</u>	Heal Heal Heal		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place		apolis, MI Date	20c. Location - C	City or Town	n, State
E 0	Pages nent of h int: If it		1 ☐ Burial 2 🕅 Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	9	Cremator		5-2004 I	Falls Ch	urch.	VA
Baltimore,	permit. Pages Department of Important: If it any injuty or o		21. Signature of Funeral Service License	tottlen	ner 1	Name and Address Danzansky	ss of Facility Goldber	rg Memoria ike, Rocks	al Chape	1, In	.C.
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8/60,	icate be executed physician and sthe burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
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1	w requires that been signed by should be deta	by	Part II. Other significant conditions cor Hypotension	tributing to death	but not resulting in the u	nderlying cause give	en in Part I.		es 2 XNo 3		cause of death?
Hecords,	e la has	Completed	Pacemaker					24a. Was ar autops perform	y pri ned? de	ere autopsy ior to compl ath?] Yes 2[r findings available letion of cause of
ıta	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					eath (Check only on	9)		
Division of Vital	ing Phys After this uneral di	은	1 Yes 2 No P 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	tient 2 ER/Outpatier jury 28b. Time o lay Year) Injury	f 28c. Injun Work	at at	Home 5 Reside	nce 6 Other	(Specify)	
DIVIS	tel or Attend rs after death el Director: , ed in by the f	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of li building, e	njury - At home, farm, st atc. (Specify)	reet, factory, office		28f. Location (Sti City or Town		or Rural R	oute Number,
	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	edicai	one) 2 Medical Examil	sician: To the bes ner: On the basis and manner s	st of my knowledge, deat of examination and/or in stated.	vestigation, in my or	oinion, death oc	curred at the time, da	ite and place, an	id due to the	e cause(s)
		Σ	29b. Signature and title of certifier	.111.	00-711.	29c. License	number	29	d. Date signed	(Month, Day	y, Year)
	10		surege		es Theo		23170		March	1, 20	004
			30. Name and address of person who co		death (Item 23a) (Type, 406 Old Geo	•	ond D-	thouse 3	/ 2001		
	Sta * Registr	100	31. Date filed (Month, Day, Year) MAR 0 9 2004	32. Regis	trar's Signature	Sports		rnesua, M	D 20014		

			1 - For State Registrar	State of	Maryla	nd / Depa	artmen <i>rtificat</i>	t of H e of L	lealth a D <i>eath</i>	and M	fental Hy	/gien Reg. N		104	096	65
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	Examir		4e. Fecility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	of Death		4	c. Count	y of Deeth		
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ø,	Funeral		5. Social Security Number 6. S	9x □M 2XIF	7. Age (In yrs 82	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of B	ev. Yeer	201	_ Cou	place (State of ntry)	
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	ow ow		10a. State 10b. County		10c. C	City, Town or Lo	ocation								10d. Inside Cit	ly Limits
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	th wit	Funeral Director	709 Fordham Street				208	850				Uni	ted	State	28	
	deel me	ner	11. Marital Status	12. Was Deced			Was Deced	ient of Hi	spanic Orig	gin? (Sp	ecify Yes or N Rican, etc.)	0-		ce - Ameri	can Indian,	
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	alth a		Lewis A. Piccolin	o/Son		709 E	ordha	ım St	reet	, Ro	ckville	e, Ma	ary1	and 2	0850	
J.	of He of He item		20a. Method of Disposition	D	20b.	Place of Dispo cemetery, create te of	sition (Nan	ne of ther place	e) M	arcl	Pate),	20c. L	ocation	- City or T	own, State	
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Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any injury or other trai		21. Signature of Funeral Service Licen	600	мо	1353 R	2. Name an OCKVI.	d Addres	Inc.	yRobe 300	ert A. West 1 1 20850	Pump Mont	ohre gome	y Fun	eral H	ome/
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ds	requires een sign nould be	d b	Emphysema								1 🔯	Yes 2	!□No	3 🗍 Prot	abiy 4 🗆 U	nknown
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1 2 Accident 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Registrar's Signature 31. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34. Certifier 29d. Date signed (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 33. Date filled (Month, Day, Year) 32. Registrar's Signature 34. Certifier 24. Certifier 25. Certifie	00	> 0 0	ojete										24b. We	ere autor	osy findings available
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	(io		30. Name and address of person w	no completed cause o	of death (Item 23a) (Typ.	Print)	ð- €	¥100	P	ockvill	٩	MO	20	850
	100														

State of Maryland / Department of Health and Mental Hygiene 2001 09667 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** March 6, 2004 6:45pm^M Maria Pena /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11801 Rockville Pike #214 Montgomery <u>Rockville</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Yrs 85 Sept. 24,1918 089-42-5876 Equador Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show Examiner rivet be notified at 1 ☐ Yes 2 No Maryland Montgomery Rockville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With itams 23a or 11801 Rockville Pike #214 20852 United States permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene imported: if Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Experiment once. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 Yes 2□ No Specify: Equadorian Baltimore, Maryland 21215-0036 Specify. White 3 XWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Housekeeper Private Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maria Santos Quinto Jesus Maria Pena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11802 Rockinghorse Road Rockville, Maryland 20852 Edmundo Pena / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 10, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 2004 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on a ch line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Disease <u>Years</u> resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, loading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒No 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 3 Probably 4 □Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 ☐ Yes 2 🔀 No 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Medical Certification: To 1 X Yes 2 ☐ No this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural M 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated within 2 29b. Signature and fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) D55152 March 8, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4701 Randolph Road #101 Rockville, Maryland 20852 Gino E. Mendoza, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 09 Registrar

State of Maryland / Department of Health and Mental Hygiene,

For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, MARCH 6 Day 2004er **Physician** PATGE EVELYN JOSEPHINE 3:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville MONTGOMERY Collingswood Health Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 30, 1921 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M **2**1 F Maryland 82 236-58-1761 Director Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show Examiner must be notified at 1X Yes 2 □ No Montgomery Gaithersburg Director MD the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 Chestnut Street 20877 U.S.A. Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after I □Yes 2X No If Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 ō Specify: Black 1 ☐ Yes 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Year or Dates: "naturel', 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Complet Home Health then. Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Self-employed Care Aide 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Wesley Jackson Julia Kimbrough 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 19a. Informant's Name/Relationship (Type, Print) Patricia Horton (Daughter) 9 Chestnut St. #211, Gaithersburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ō <u>=</u> 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If 3/11/04 All Souls Cemetery Germantown, MD 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Şignature of Föneral Servi vicens any ir corge 246 N. Wash. St., Rockville, MD 20850 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Alzheimer's Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Seizure Disorder Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included and the conditions) Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physiclan/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No Ö the 9□ Unknown 9 Unknown þ يَم signed byF Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 Probably 4 □Unknown 1 Yes 3 No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Instruction | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Supering Home | Superin 1 ☐ Yes 💥 No 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funaral Diractor: in by the 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of centries 29c. License number 10 D37801 Mar. 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amiee Seidman, M.D. 11906 Darnestown Road, Gaithersburg, MD 20878 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 11 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 3, 2004 3:10 a Mar. Cecil Winston Phillips /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Trinidad& Tobago 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 13℃ M 2□ F 43 217-06-2104 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic event, If a Madical Examinar many or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 1 1 1 0 0 MD Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 Trinidad & Tobago 1511 December Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☎ No If Yes, Give Year or Dates: 1 Never Married 2 Married **Black** 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Private Business 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Salome O'Connor Gibbon Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6818 Greencrescent Ct., Greenbelt, MD Dane Phillips - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hope Anglican Church Cemetery 3/12/04 Tobago * 4 ☐ Donation /5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home 21. Signature of Funeral Service Licenses 20781 4739 Baltimore Ave., Hyattsville, MD 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myo Cardial infarction **Physician** 1 x Day /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hoapital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by should be 1 Gs 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 2 No funeral director, Medicai Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√No 2 P/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation thours after death. uneral Director: Aft sly filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29c License number 29b. Signature and title of certifier Tom P. Kannarkat MD D-20062 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BST, SILVER SPRING, MARYUND State Registrar

State Registrar

MAR 08 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sparks

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Rpd	1- State	Item #3 State of Manyland/Deprentings of Health and M Certificate of Death	Mental Hygiene 2004	0967
Physician	1. Decedent's Name (F)		2. Date of Death Month Day Year	3. Time of Death 11:45 P

/Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any ningury or other traumatic event. The Medical Exempliar Instal Let Indiffed at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Registrar			rtificate of De			F.eg. No.		0967
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a. Facility Name (If not institution, gir	ve street and number)		4b. City, Town, or Lo	ocation of Dea	th	4c. Cou	inty of Death	
Viers Mill Road &			Rockville				tgomer	
	Sex 7. Age 1 XM 2 ☐ F	(In yrs. last birthday)		f Under 24 Hrs Hours Min	(Month, D	ay, Year)	Cou	place (State or Fore intry)
216-67-8930 Jsual Residence of Decedent		55 Yrs.			Oct.	16, 19 ²	18 In	donesia
0a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Lim
Maryland Montg	omerv	Rocky	ville					1 ☐ Yes 2 💢
0e. Street and Number	ome 2 y	ROCK	10f. Zip Code			10g. Citizen	of What Cou	intry?
12907 Crookston	Lane #12		20851	l		Inc	lonesia	a
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3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	162 Door	dent's Usual Occupation	20		16b Kind o	of Business/Ir	aduetn/
(Specify only highest gi	rade completed)	(Give	kind of work done dur DO NOT use retired)	ring most of wo	orking	100. Kand d	n Dusinessyn	idustry
Elementary/Secondary (0-12)	College (1-4or 5 17+	+)	Clergy				Churc	h
7. Father's Name (First, Middle, Las		1		8. Mother's Na	me (First, Middle	, Maiden Sun		-
Daniel Pattia	nakotta			Fr	ansien P	attian	akotta	ı
9a. Informant's Name/Relationship			ng Address (Street and	d Number or A	ural Route Numb	er, City or To	wn, State, Zi	
oyce Rarumangkay	- personal	rep. 480	06 Nash Dri	ive, Fa	irfax, V	7A 2203	12	=1,07,
0a. Method of Disposition	70	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)		Date	20c. Location	on - City or T	own, State
1 Burial 2 ☐ Cremation 3 C 1 Donation 5 ☐ Other (Spec			Heaven Cem.	3-6	-2004	Silver	Sprin	ng, MD
1. Signature of Funeral Service Lion	ensee	22	2. Name and Address	of Facility H i	nes-Rina			
Doollow	SITO	11	1800 New Ha	ampshir	e Av., 5	ilver	Spring	g, MD 209
23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that or used	the ath. Do not ent	ter the mode of dying,	such as cardia	c or respiratory a	arrest,		Approximate Interval Between
Sequentially list conditions,	b. Due to (or as a	a consi∗ uence of l:						
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State

Registrar

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	Physici /Medio		1. Decedent's Name (First, Middle, Last)	Queen				2. Date of Dea Month MARCH	Day Year 04 2004	3. Time of Death
	Examir		4a. Facility Name (I not institution, give s Doctor's Community 5. Social Security Number 6. Sex	y Hospital 7. Age (In yrs.	last birthday)		Lham If Under 24 Hrs. Hours Min.	8. Date of Birtl		th George's thplace (State or Foreign ountry)
	Director		212-86-7931 1 Usual Residence of Decedent	M 20XF 41	Yrs.	Months Days	Hours Will.	Nov. 15	, 1962 Ma	ryland
	Marylan	tor	10a. State 10b. County Maryland Prince Ge		y, Town or Lo Rive					10d. Inside City Limits 1 ☐ Yes 2X No
	with the	Director	10e. Street and Number 6317 61st Place	8-		10f. Zip Code	:0737		10g. Citizen of What Co	•
36	i within 72 hours after death with the Maryland liene. I them atural; or Iteme 23a or 28e-1 show the Medical Examinet must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 ⊠ No If Yes, Give			ispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	Specify:	encan Indian, te, etc.
Maryland 21215-0036	within 72 hours ene. than *natural', to we died Ex	Completed b	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation a completed) College (1-4or 5+)	(Give	OO NOT use retired	during most of workird)	ng	16b. Kind of Business	White Andustry ge's County
Id 21	Hyg othe	Be Con	12 17. Father's Name (First, Middle, Last)		Scho	ool Bus A	18. Mother's Name	(First, Middle,		rge's County
ırylar		ToB	Jack L. Finchar 19a. Informant's Name/Relationship (Ty		19b. Mailin	g Address (Street			almberg r, City or Town, State,	Zip Code)
	s 1 and 2 should if Health and Mer item 27 is marke other treumatic		James C. Queen - H		- Committee	61st Place	ce, Riverd	lale, M	D 20737 20c. Location - City or	Town, State
Baltimore,	O		1 № Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren t Linco	natory or other place In Cemeter	y 03/08	/2004	Brentwood	, Maryland
Balt	permit. Page Department of Important: If any injury or		21. Signature of Fun ral Service Licente	May	47	Name and Address 39 Balti	^{ss of Facility} Gase more Avent	ch's Fu ue, Hya	neral Home ttsville, I	P.A. MD 20781
E.			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cau on each line.				r respiratory ar	rest,	Approximate Interval Between Onset and Death
100	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseq	uence of):	ctory 1-	ailure			onemonth
50,	icate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or	uence of):	Inters	titial	Pneu	monitis	8 yrs
.O. Box 68760,	The law requires that the death certificate I ate has been signed by the attending physt page 2 should be detached for use as the I	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	Ideath 3	Ectopic pregnancy	,		23d. Date ol de Month	livery Day Year
٥.	quires that in signed build be deta	þ	Part II. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to res 2. 200 3 □ P	o the cause of death? robably 4 DUnknown
il Records,		Completed						24a. Was autop perfor 1 \(\text{Yes} \)	sy prior to death?	utopsy findings available completion of cause of 2 No
f Vital	ysic is ce direc	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	lospital: 1 Inpatient 2	ER/Outpatier	it 3□ DOA Oth	26. Place of Death er: 4 \(\sum \) Nursing Hon		ne) Ience 6 □Other (Spe	ocify)
ion of	ding After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division	- = E	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str y)	eet, factory, office	2	281. Location (S City or Tow	Rtreet and Number or R m, State)	ural Route Number,
	To the Hospitel of within 24 hours aft To the Funerel D completely filled in	Medical (sician: To the best of my kno ner: On the basis of examina and manner stated.						
1	withir To th	M	29b. Signature and title of certifier	• 0		29c. Licens			29d. Date signed (Mon	th, Day, Year)
)_	(5)		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type,	Print)	. 015		3-4-04	
		ate	31. Date filed (Month, Day, Year)	erg 6492 Lo 32. Registrar's Signa	ature	er Rd, L	andover	MO:	20785	
	Regist	rar	MAR 0 8 2004	Death A.	GOSA	U				

DHMH 17 Rev 1/2001

Queen, Jacquelyn

			1 - For State Registrar		Maryland	d / Depa <i>Cei</i>	artmen rtificate	t of H e of L	ealth a	ind M	lental Hyg	iene g. No. 2 (004	09673
1	Physici	an	Decedent's Name (First, Middle,	Last)							2. Date of Deat Month		Year	3. Time of Death
,	/Medi	cal	Frances M.								March	1, 200)4	2:56 A ^M
	Examir	er	4a. Facility Name (If not institution, Genesis Crescen		-				Location of	f Death		forth 1, 2004 4c. County of Death Prince Georgian Prince Ge		
Н	Funeral			Sex 7. A	Age (In yrs. I	ast birthday)	If Under	erda 1 Year	If Under 2	24 Hrs.	8. Date of Birth	Princ	e Geo	orges
	Director		228-22-3653 Usuel Residence of Decedent	1□ M 2 F	81	Yrs.	Months	Days	Hours	Min.	Jan. 21	, 1923	Vir	ace (State or Foreign ry) ginia
	yland		10a. State 10b. County		10c. City	, Town or Lo	cation						10	d. Inside City Limits
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	vith th	Dire	10e. Street and Number				10f. Zip				10	g. Citizen of	What Count	ry?
	eath v	eral	3141 24th Stree	12. Was Deceder	t Even in 11 (2 10 1		018						
990	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be recitived at once.	by Funeral Director	Never Married 2 Married Widowed 4 □ Divorced	Armed Forces	? X No		was Deced f Yes, spec 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No- Rican, etc.)	Blac	ck, White, e	tc.
Maryland 21215-0036	thin 72 ho e. en "netur	Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+)	16a. Deced (Give life. L	lent's Usua kind of wor DO NOT us	k done di	urina most	of workir	ng	6b. Kind of B	usiness/Indu	ustry
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yland	buld be fil Mental H arked otl	To Be	17. Father's Name (First, Middle, La William Mooref	leld				1			(First, Middle, M Spraggi		16)	
	and 2 shi alth and 27 Is m er træum		19a. Informant's Name/Relationship Layton Ray / Hus											Code)
Baltimore,	es 1 a of He fitem r othe		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3	Demoval from State	00	ace of Dispo	sition (Nam	e of	1					m, State
Ĕ	Pag ment tent: I		'4 □Donation 5 □ Other (Spe			t Line	oln (Cem.	Ma					
Sail	Depart Depart Import any inj		21. Signature of Funeral Service Lic	ensee	(2)				-				•	
	005 60		222 Part Enter the disease of a	JUNINS										
	Physician /Medical		23a. Part. Enter the disease, or consider of heart failure. List on immediate Cause (Final disease or condition resulting in death)	.a. 51	line.	21		or aying	, such as c	ardiac oi	respiratory arre	st,		Approximate interval Between Onset and Death
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8760,	cate be executed ohysiclan and the burial-transit			d				-						
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	quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death	but not resul	ting in the un	derlying ca	use giver	n in Part I.					
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Viita	ysicien: The is certificate hi director, page	Be	25. Was case referred to medical examiner?						26. Place o	f Death	(Check only one)	0110		- 140
5	Shysia this call dire	ပ္	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpat		R/Outpatient			4 Nurs					
Division of	Attending Physicien: r death. ector; After this certifics by the funeral director, p	atlon:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati		ury ay Year)	28b. Time of Injury	M 28	c. Injury a Work? 1 🗀 Ye	at es 2⊡No	i	Bd. Describe how	injury occurre	ed	
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	To the Hospitel or within 24 hours afte To the Funerel Dirk completely filled in It	edical	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best aminer: On the basis of and manners	or examinatio	ledge, death on and/or inve	occurred at estigation, i	t the time n my opir	, date and prion, death	place, ar occurred	nd due to the cau d at the time, dat	se(s) and mar and place, a	ner as state	ed. ne cause(s)
	vithi Com	Ž	29b. Signature and title of certifie			Non	29c.	License r	redmur	7	290	Date signed	(Month, Da	y, Year)
_ (1)		30. Name and address of person when the state of the stat	completed cause of	death (Item 2	23a) (Type, F	Print) A	LE	KAN	DE	RE	I.	JKi	14°
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 8 20		rar's Signatu	los	W				1000			

State of Maryland / Department of Health and Mental Hygiene For State Registrar 09674 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** March 05, 11:55AM Florence 01verson Rogers /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year, Nov 20, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 280 F 92 New York 579-01-4928 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State r than "natural", or Itams 23a or 28a-f shov the Medical Exercites must be notified at 1X Yes 2 No Worcester Ocean City Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 803 Harbour Drive 21842 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or lian any injury or other traumetic event. Its Medical Eventual and once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charlotte T. Lauer August J. Fitter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 803 Harbour Drive Donald Olverson- Son Ocean City MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 3/9/2004 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MUOCZ hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day Year Month 4 Pregnant at time of death 5 Other (specify) o. 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ØUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ■ npatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) ဥ 1 ☐ Yes 2 No After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To tha Funaral Diractor: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide De Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9733 Duckes Drive 31. Date filed (Month, Day, Year) MAR 0 9 2004 82. Registrar's Signature State Registrar

	_	For State Ragistrar	_	or Man	*	epartme Certifica					Reg. No.	2111	
Physicia	n	Decedent's Name (First, Middle DEDNIT OF DOD'T								2. Date of D	Day		1 111410
/Medica	al	BERNICE ROBI 4a. Facility Name (If not institution		umber)		4b. Cit	y, Town, or	r Location	of Death	MAKE		County of D	7
Examine	er	DOCTOR'S HOSP					LANHA					•	EORGE'S
Funeral Director		5. Social Security Number 578-22-9752	6. Sex 1 □ M 2 🙀 F	7. Age (/ 85	In yrs. last birt	hday) If Und Month	er 1 Year s Days	If Under Hours	Min.	8. Date of B (Month, D 7 26	irth Day, Year) 191	9. I MA	Birthplace (State or Fore Country) RYLAND
and	-	Usual Residence of Decedent 10a. State 10b. County		10	0c. City, Town	or Location							10d. Inside City Lim
Mary fiels	to	MD PRINCE	GEORGE'S	3	BOV	VIE							1 XYes 2 □
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Important: If i any injury or once.		21. Signature of Funeral Service	hall				LANDO	VER R	OAD 1	LANDOV	ER, M		ERAL HOME ND 20785
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within 24 hours a To the Funeral I completely filled	Medical (29a. Certifier (Check only one) ertifyin	g Physician: To the Examiner: On the and ma	ne best of r basis of ex nner stated	camination and	, death occurre d/or investigation	ed at the time on, in my of	ne, date ar pinion, dea	nd place, a ath occurre	and due to the ad at the time	e cause(s) o, date and	and manner place, and d	as stated. lue to the cause(s)
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-675 NO		30. Name and address of person	who completed ca	use of deat	th (Item 23a) (Type, Print)		- 1		- /	4 1		1 20107
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State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ROSEN MARCH 4, 2004 10:25 PM CHARLES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUBURBAN HOSPITAL MONTGOMERY BETHESDA 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months 81 MARYLÁND Director 219-14-0987 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 □ No Directo MARYLAND MONTGOMERY CHEVY CHASE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8525 GAVIN MANOR COURT 20815 UNITED STATES or items 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Completed by 3 Widowed 4 Divorced WHITE "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER DESIGN STUDIO FURNITURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be YETTA MORRIS DAVID ROSEN FRIEDRICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IRENE ROSEN, 8525 GAVIN MANOR CT., CHEVY CHASE, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Cremation 3 Removal from State 1 X Burial 3/8/2004 5 Otber KING DAVID MEM. GDN. FALLS CHURCH, VIRGINIA une al Servic 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signalure of the 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of) **Examiner** 12 HOURS **BRAIN HERNIATION** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last Due to (or as a consequence of) Examine INTRACEREBRAL BLEED Due to (or as a consequence of) Physician/Medical MALIGNANT HYPERTENSION IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 XNo Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 XNatural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after of To the Funeral Direc 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 47867 MARCH 5, 2004

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

10,05pm

Rosen

ROCKVILLE, MD

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4701 RANDOLPH ROAD, #101

WWIGA, M.D.,

MAR 0 9 2004

31. Date filed (Month, Day, Year)

						k Indelible Ink Department of I	Health and M	-	iono	1 0000
			For State Registrar			Certificate of	Death	R	eg. No. 200	4 096/8
1	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Deat Month March	Day Year	3. Time of Death 7:350M
20	/Medic		Elizabeth Riguel 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	TIM OF	4c. County of Dea	
	Examin	er	Doctor's Communit			Lanhan			Prince G	eorge's
	Funeral		5. Social Security Number 6. Se	ex 7. Age	(In yrs. last bir	thday) If Under 1 Year Months Days		8. Date of Birth (Month, Day,		thplace (State or Foreign
\	Director		220-76-3021	□ M 2KO F 4	3	Yrs. Mortins Days	Hours Will.	Feb. 24,	, 1961 Wasl	nington, DC
7	pu »		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
Ci	anyla shov	5								1 ☐ Yes 2 ☐ No
36	ith the Marylar or 28a-f show	ecto	Maryland Prince G	eorge's	Bei	wyn Heights 10f. Zip Code	3	1	0g. Citizen of What Co	ountry?
ELIZABET 0036	after death with the Maryland or items 23a or 28a-f show miner must be multifud at	D.	8412 57th Avenue			2074	in		U.S.A.	,.
N	ns 23	era	11. Marital Status	12. Was Decedent Ev	ver in U.S.	13. Was Decedent of I		ecify Yes or No-	14. Race - Ame	
9	after or item	Ē	1 ☐ Never Married 2 📉 Married	Armed Forces?	0			Hican, etc.)	Black, Whit	le, etc.
77	ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	Vhite
RISUEIME, EL Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Modeal Examiner must be notified at once.	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	lucation ide completed)	16a.	Give kind of work done	pation during most of worki	ng	16b. Kind of Business	/Industry
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四日	Hygie ther int.	ပိ	12 17. Father's Name (First, Middle, Last)		1 1.6	egal Support	18. Mother's Name			.I.L
a S	d be	To Be	Pietro Dastoli				Barbar	a Maiolo		
ISUEIME, Maryland 212	Shoul nd Me mark	ř.	19a. Informant's Name/Relationship (7	Type, Print)	196	. Mailing Address (Street	t and Number or Rura	I Route Number	, City or Town, State, .	Zip Code)
M	nd 2. alth ai 27 is r trau		David_Riguelme/H	lushand	84	12 57th Ave	. Berwyn	Heichts.	MD 20740	
)()	s 1 a of Hea item		20a. Method of Disposition		20b. Place of	Disposition (Name of ry, crematory or other pla		ate	20c. Location - City or	Town, State
2/00	Page int: #		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	(Removal from State y)		of Heaven		5, 2004	Silver Spi	ring, MD
	mit. partm ports y inju		21. Signature of Funeral Service Licen	fsee			ess of Facility Hin			
_ B	8958		xon 1.7/	Ut						ng, MD 20904
			23a. Part1. Enter the disease, or company shock, or heart failure. List only	plications that caused tone cause on each line	the death. Do	1 1		. 0	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a DM	etuj7	ratio Pa	nereated	Ca	ncer	011001 4110 00411
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):				
	Be +	_	Sequentially list conditions,	b. Due to (or as a	consequence	of) with				
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ŏ	h cert endin	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		3 □Ectopic pregnanc	ev		23d. Date of de	,
	deat ne att ed for	sicie	in the past 12 months?	4□Pregnant at ti		5 ☐ Other (specify) _			Month	Day Year
P.O.	that the death certificate ed by the attending phys detached for use as the	Physician/Medic	9 Unknown			- 45		22a Did tob	pacco use contribute to	a the seuse of deeth?
Division of Vital Records, P.O. Box 687	Physician: The law requires that the death certificate this certificate has been signed by the attending physeral director, page 2 should be detached for use as the	by	Part II. Other significant conditions of	ontributing to death but	it not resulting i	n the underlying cause gi	Bleeden			robably 4 Donknown
oro	requi	eted	0 110	G-03/C/2	in 19	1000				
ခွင	sician: The law certificate has b irector, page 2 s	Completed						24a. Was a autops perform	n 24b. Were at prior to death?	utopsy findings available completion of cause of
a la	n: The	Ö						1 ☐ Yes 2	2 DNo- 1 ☐ Yes	2 No
Vit.	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:		05 50. Ot	26. Place of Death			
ō	ling Phys n. After this funeral di	. To	1 Yes 2 No 27. Manner of Death	1 Anpatien 28a. Date of Injury (Month, Day		Time of 28c. Inju	4 Nuising Ho		ence 6 Other (Spe ow injury occurred	icity)
on	Attanding or death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident investigation		Year)		ork?]Yes 2 □No			
<u>isi</u>	Attandiu r death. ector: A	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur	iry - At home, fa	arm, street, factory, office		28f. Location (St City or Town	reet and Number or R	ural Route Number,
از	s afte	Certification; To	4 Normalde	building, etc.	. (Specify)			City or Town	, Siai6)	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	cai	(Check only 2 Medical Exam	miner: On the basis of	examination ar	e, death occurred at the t				
	tha H hin 24 tha F nplete	Medical	one)	and manner state				· · · · · · · · · · · · · · · · · · ·	9d. Date signed (Mont	
	P P S	-	29b. Signature and title of certifier	· Anta	uli		830196	7	2 1 04	/ Day, rear)
	3(5)		00 Normania	11:-	and the control				2/1/	
_			30. Name and address of person who AMIKAI	AMJADA	Z 81	18 Gna	1 Luck	Rd 2	axan,	MD 2070
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 9 20	32. Hegistral	er's Signature	& Spark	ad			

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mar. 10, 2004 4:50aKADIJATU RAZZAK /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 01 ney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociat Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F 86 Dec.3,1917 Sierra 212-17-6014 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10b County 10c. City, Town or Location or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Silver Springs Montgomery Maryland Director 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number with 1 20905 USA 1201 Windmill Lane Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a intry or other traumatic event, the Medical Examinal must be 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 ☑ Widowed 4 ☐ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Home Homemaker 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abdul Rahman Geblaoui Aisha Dumbuva ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1913Briggs Chaney Rd, Silver Spring, Md. 20905 Abdul Majid Razzak-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Wash. Cemet. 3-11-04 Adelphi, Md. permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mortuary 21. Signature on Funeral Service Licensee 411Kennedy St, N.W., Wash, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death tmmediate Cause (Finat ASPIRATION Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** MELLITUI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 980 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably HYPERTENISION 4 []Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 22 No 24a. Was an autopsy performed? 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D37243 1 amin 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenway Center Dr. Greenbelt Md. 20770 7525 Ramesh Patiol, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oaks MAR 11 Registrar

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	Physic /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March Q 2. Date of Death Month Day March Q 2. Date of Death							3. Time of Death			
	Examir		4a. Facility Name (If not institution, give street and number) Suburban Hospital				4b. City, Town, or Location of Death Bethesda				4c. County of Death Montgomery		
	Funeral Director		5. Social Security Number 577–38–7785	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs. I 76	last birthday) Yrs.	If Under 1 Year Months Days			irth Day, Year 28, 1	9. Bir 928 Wa	thplace (State or Foreign country) shington, D	
9	land		Usual Residence of Decedent 10a. State 10b. County 10c. City			y, Town or Location						10d. Inside City Limits	
	Mary -f sh	to	Maryland Montgomery Roo			Rockvi	ockville					1 ☐ Yes 2 🖾 No	
	r 28a	Director	10e. Street and Number								g. Citizen of What Country?		
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	hours after death with the Maryland turel; or Itame 23e or 28e-f show a Exercitive mart be redified at	by Funeral	11. Marital Status 12. Was Decedent E Armed Forces? 1 Never Married 2 Married 1. Yes 2 🕅		rces? 2⊠No	If	Vas Decedent of I Yes, specify Cub	Specify Yes or Note Rican, etc.)	ecify Yes or No- Rican, etc.)		Race - American Indian, Black, White, etc.		
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Maryland 21215-0036	thin 72 h e. en "natu Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)			(Give F	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)				16b. Kind of Business/Industry		
7	be filed wiltal Hygien d other the	Con	12			Secretary				Florist			
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<u> </u>	ould Men Marks		Achilles Orphanos				Catherine Byron						
ā	2 sh and is m		19a. Informant's Name/Relatio				ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Baltimore, I	1 and 1ealth om 27		Michael S. Ray	// Son	20h BI	5220	Contine	ntal Dri	ve, Roc				
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Martical Exercities in the trained be rediffed at once.		1 ⊠Burial 2 □ Cremation 1 □ Donation 5 □ Other		06	ametery, crem	sition (Name of latory or other play Memoria k	Marc 20	h 15,		ocation - City or $kville$.	Town, Stete Maryland	
Balt			21. Signature of Funeral Service Ligensee Browley francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901										
Ŧ	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a.						Approximate Interval Between Onset and Death				
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	es the igned	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to								the cause of death?		
records		Completed							24a. Was	an	24b. Were au	topsy findings available ompletion of cause of	
NII A	sician: The law certificate has b irector, page 2 s	Be Co	25. Was case referred to medical				performer 100 Yes 2 ☐ 26. Place of Death (Check only one)			2 🗆 No			
	Physician: this certific al director,	10	examiner? 1 XYes 2 ☐ No	Hospital: 1 XIIn	patient 2 🗆 E	R/Outpatient	3 DOA Oth	-			6 □Other (Spec	ifv)	
5	ath. r: After the	ation:	27. Manner of Death 1 Natural 5 Pend 2 Accident inves	28c. Injury at Work? M 1 Yes 2 10 No et, factory, office 28d. Describe how injury occurred to the motion of a m				y occurred notor Veh	ide which				
222	spital or Attending ours after death. Peral Director: After filled in by the funer	ertific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)					and Number or Rural Route Number, ate) Viers Mill Rd and					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									stated	
	To the Hos within 24 h To the Fur completely	₩	29b. Signature and title of certifier				29c. License number 29d			29d. Date	9d. Date signed (Month, Day, Year)		

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State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) MAR 12 2004

hi.

mid

32. Pegistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

March 10, 2004

		Registrar	1	Ce	rtificate of	t Death		Reg. No. 20		368
nysicia	ın	Decedent's Name (First, Middle, EILEEN ZIM					2. Date of Dea Month MARCH	_	3. Time 7:06	of Death
Medica xamine		4a. Facility Name (If not institution,			4b. City, Town,	or Location of Deat		4c. County of		. 1
A GITTITIC	'	SUBURBAN HOSPITA			ВЕТН	ESDA		MONTGO		
neral			1□M 2□E	s. last birthday)	If Under 1 Yea Months Days		8. Date of Birtl (Month, Day	14, 1929	9. Birthplace (State Country)	or Forei
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14		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside	City Limi
Lillied	ctor	MARYLAND MONTGO	MERY	CHEVY	CHASE				1 🗆 Ye	s 2 7
and injury or other traumatic event, the Medical Exameter must be notified at once.	Dire	10e. Street and Number	PHTP #212		10f. Zip Code		10g. Citizen of What Country?			
THE	era	4701 WILLARD AVE	NUE, #/1/					UNITED		
Dict	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Marned	Armed Forces?	0.5.	If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)	Black,	- Americen Indian, White, etc.	
Eran	by	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	tf Yes, Give A Year or Dates:		o Specify:		Specify:	WHITE	
dical	eted	15. Decedent's (Specify only highest		16a. Dece	dent's Usuat Occu	upation e during most of wo	rking	16b. Kind of Busi		
a Me	ig I	Elementary/Secondary (0-12)	College (1-4or 5+)			e during most of wo red)	9			
# (F	ပ္ပို	12 17. Father's Name (First, Middle, La	ist)	SEC	RETARY	18 Mother's Nar	me (First, Middle,	INSUE		
C eve	o Be	ROBERT	SHAPIRO			BESS		LEHM		
umat		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Stree	et and Number or Ru				
er tra		BARRY ZIMAN, SO	N		S. EADS,		RLINGTON,			
r oth		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location - Ci	ity or Town, State	
90		1 Burial 2 Cremation 3 1 Donation 5 □ Other (Spe		W MONTE	FIORE CE	EM. 3/9	/2004	PINELAWN	N, L.I.,	NY
ny inj		21. Signalure of uneral service Lit				SEL FUNERA				
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Cien		23a. Pent. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	omplications that caused the deality one cause on each line.	ath. Do not ent	er the mode of dy	ring, such as cardiac	or respiratory arr	est.	Approxim	
		disease or condition	TERITOI	VITIS	2	,	, , , ,		Interval Be Onset and	Death
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DHMH 17 Rev 1/2001

Ravin, Eileen Oxfosfog 7:06 PM

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			Decedent's Name (First, Middle, Last)		· · · · · ·			2. Date of Dea		3. Time of Death	
	Physici: /Medic		ANDREW MICHAEL R	OCCELLA				MÄRCH	H 14, 2004 1420		
	Examin		4a. Facility Name (If not institution, give street and nur INNER HARBOR NEAR FORT M			4b. City, Town, or BALTIMO	4c. County of Deat	h			
W.	Funeral Director		224-17-7430 1 [™] 2□ F	7. Age (In yrs. last 26		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		y, Year) Co	hplace (State or Foreign untry) nigan	
	and w		Usual Residence of Decedent 10a, State 10b. County	10c. City, T	Town or Loca	ation				10d. Inside City Limits	
	Manyli f sho	ō	Time in the Endows	77-1						1 □ Yes 2X No	
	r 28a	Director	Virginia Fairfax 10e. Street and Number	Vienn	ıa	10f. Zip Code			10g. Citizen of What Co	untry?	
	th with		8181 Carnegie Hall Cour	t #203		22180			USA		
	r dea	Funeral	Armed For	dent Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (Specify Yes or No- rto Rican, etc.)	- 14. Race - Ame Black, White		
36	s afte	by Fu	1 XNever Married 2 Married 1 Yes If Yes, Giv. 3 Widowed 4 Divorced Year or Da	8	10	∃Yes 2XNo	Specify:		Specify: White		
9	To a State 10b. County 10c. Co					nt's Usual Occupa	tion		16b. Kind of Business/	Industry	
215	within 72 ene. than "ne he Media	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Writer					orking		,		
21	filed wit Hygiene other tha	SET TO BE TO							Telecommuni	cations	
pu	定工 まま 17. Father's Name (First, Middle, Last)								Maiden Surname)		
yla	should be nd Mental marked c	To	Edward J. Roccella		10h Mailine	Address (Cares	Eileen		City of Town Coats	To Code	
Mai	d2 sh th and t7 is n traun		19a. Informant's Name/Relationship (Type, Print) Edward J. Roccella/Fathe		_				er, City or Town, State, Z na, Va. 221		
Baltimore, Maryland 21215-0036	ages 1 and 2 should b nt of Health and Ment t: If Item 27 is marked r or other traumatic e		20a. Method of Disposition	20b. Place	e of Disposit	tion (Name of		Date	20c. Location - City or		
OE.	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)			tory or other place tan Crema		19/04	Alexandria,	Va.	
alti	글 된 본 층 .		21. Signature of Funeral Service Licensee		22.	Name and Address	s of Facility	C FINEDA	L HOME, INC		
m	Depa Impo any is		Fichar Di of its enell		1	/I W. Maj	ole Ave.	, vienna	i, va. 22180	·	
Charles and	23a. Part1. Enter the disease, or confiplications that caused the death. Do not enter the mode of dying, such as cardiac or resistance, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Drowning and hypothermia Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Interval Between Onset and Death	
.O. Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Medical Exa	d	come of pregnancy rth 2 Fetal de- ant at time of death	y eath 3⊟E	ctopic pregnancy Other (specify)			23d. Date of deli	ivery Day Year	
<u>α</u>	that the		Part II. Other significant conditions contributing to de	ath but not resultin	ng in the und	ferlying cause give	n in Part I.	23e. Did to	obacco use contribute to	the cause of death?	
g,	sign Id be	d by						1 🗆 Y	res 2 No 3 Pr	obably 4 Unknown	
al Records,		Completed						24a. Was autop perfor 100 Yes	rmed? prior to death?	topsy findings available completion of cause of	
Vital	Physician: ' rthis certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 XYes 2 No Hospital: 1 1	antinet 2000	1/Outs stient	20 DOA Othe		ath (Check only o		ANATE COUNTY	
Division of	ling After fune	Certification: To	27. Manner of Death 1 Natural 5 Pending (Month investigation investigation 3 6 0	of Injury h, Day Year) 4	VOutpatient Bb. Time of Injury	28c. Injury Work M 1 \(\text{Y}	at at	tome 5 Pesidence 6 X Other (Specity) AT SCET 28d. Describe how injury occurred Subject drowned and was exposed to coid			
Divi	i Pire	Certif	determined 286. Place	of Injury - At home ng, etc. (Specify)	1	harbor	winter	Mc Henry		arbor near to	
29a. Certifier 1 Certifying Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/o											
	To the Hos within 24 h To the Fur completely	Med	29b. Signature and title of certifier	or stated.		29c. License	number		29d. Date signed (Montl	n, Day, Year)	
	⊢s⊢ŏ		Mai mis	>		O	OME.		MARCH 15,	2004	
			30. Name and address of person who completed cause LING LI, MIT				et, Balt	imore, M	Maryland 212	201	
I	Sta Registi		31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	0	11. Soo	12 31				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** 10:05 PM Mattie Steward February 29, 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number Days **Funeral** Months Hours 1 M 2 XF 78 S. Carolina July 23, 251-44-9714 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County and Manual Hygiene.

Is marked other than "natural", or items 23a or 28a-f show
reumatic event, the Madical Examiner must be notified at 1 Des 2 □ No New Carrollton MD Prince George Direct 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20784 USA 6223 85th Place Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates: Specify: Specify: Black þ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Oakcrest Country Club Cook 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nannie Duren Isaac Coleman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health at
Important: If Item 27 Is
any injury or other trau 3103 Good Hope Ave, #108 Temple Hills, MD 20748 Mattie Steward/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 3/8/04 Clinton, Maryland 21. Signature of Funeral Service Licent 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd, Camp Springs, MD 20748 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC BRACLYARRYTHMIS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ASPIRATION PNEUMONIA Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): Box 68760, Physician/Medicai as IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۵ CHRONIC RENAL FAILURE 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? certificate has I rector, page 2 s autopsy performed 20 No 2 No DECUBITUS ULCER 1 Yes Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation s after decrei Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) vithin 2 To the F complet 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number AHENDING. 3-1-04 Bullenn D42580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5632 Annapolis Rd, Ste #13, Bladensburg, MD 20710 Parmjit S. Aujla 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 1 0 2004 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2004 March 12:01 PM Audrey M. Simms /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 8, 1935 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Days 1□ M 2□ F Yrs. Wash., DC Director 579-46-6296 68 Usual Residence of Decedent permit. Peges i end 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any Injury or other traumetic event, It's Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □¥es 2 □ No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2231 Beechwood Road 20783 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. AITICan 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No ģ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Military 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Security Personnel Specialist Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rudolph E. Simms Melvine Fortune 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Wrenn - Daughter 2231 Beechwood Rd., Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/12/04 Ft. Lincoln Cemetery Brentwood, MD 22. Name and Address of Facility 21. Signature Funeral Service Licensee Stewart Funeral Home 20019 4001 Benning Rd., N.E. Wash., DC ewa each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, or complications that or heart failure. List only one cause on Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CERUCAL Examiner Examiner the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Sunknown <u>م</u> Completed 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause of death? 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes edicai Certification: To No. this After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel
2 Accident 5 Pending investigation within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 35826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20912

DHMH 16 Rev 6/95

State Registrar DR. HORACIO

31. Date filed (Month, Day, Year)
MAR 1 1 2004

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04-1628	8		State of Maryland / Department of Health and Maryland / Department / Depa	Mental Hygi	ene2004	09685					
				2. Date of Death	y U21 og. No.	3. Time of Death					
	Physicia		1. Decedent's Name (First, Middle, Last) Pamela Lee Stillwater	Month	Day Year 4, 2004	1327 P M					
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death						
9			12982 HOLLY LANE LUSBY 5 Social Security Number: 6 Sax 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	CALVERT	place (State or Foreign					
8	Funeral Director		5. Social Security Number 6. Sex 1 Date of Birth 9. Social Security Number 230 76 2996 1 M 24 F 51 Yrs. Social Security Number 1 Days Hours Min. April 30 1952 Vi								
(Y)			Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location								
	Maryla f ehov	ē	Maryland Calvert Lusby			1 ☐ Yes 2X No					
	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f ehow ent. It a Me Jical Exartinar must be notified at	by Funeral Director	10e. Street and Number 12982 Holly Lane 10f. Zip Code	10	og. Citizen of What Co	untry?					
	ath will	raiD	HOLLY Way 2065/	t - V N-	United S						
	ter de	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Rican, etc.)	Black, White	, etc.					
9036	ours al	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: W	hite —————					
21215-0036	n 72 h "natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/I	ndustry					
212	d within 7. giene. ir then "n tre Medi	Jmo:	Elementary/Secondary (0-12) College (1-4or 5+) 1.2 4 unknown		unkno	wn					
pu	be file tal Hyg od othe	Be		ne (First, Middle, N							
Maryland	nd 2 should be filed within and Mental Hygiene. 27 is marked other then r traumatic event. If a Me	ပို	Frank Robert Greene, Sr. Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru.		Hallman City or Town, State, Z	ip Code)					
	alth an 27 is or trau		Frank R. Greene, Jr- brotherP.O. Box 2134 Lus								
Baltimore,	Pages 1 and 2 nent of Health a int: If item 27 is ary or other tra		20a. Method of Disposition 1 Burial 2 Ocemetion 3 Removal from State 1 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) March Metropolitan Funeral S	Date 2004	20c. Location - City or	Town, State					
ᄩ			*4 □Donation 5 □Other (Specify) 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility	ELVICEA		a virginia					
Ba	permit. Departr Imports any inji		Port Republic MD	usch Fu	neral Ho	me PA					
	4		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	est,	Approximate Interval Between Onset and Death					
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a ATHEROSCLEROTIC CARDIOVASCULAR DISEA	SE		onso, and boam					
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68	leath certificat attending phy I for use as th	Med	IF FEMALE: 23c. If yes, outcome of pregnancy		22 1 7 (- -						
Вох	leath c attend I for us	Physician/Med	in the past 12 months? I Dive birth 2 Fetal death 3 Ectopic pregnancy I Dive bast 12 months? I Pregnant at time of death 5 Other (specify)		23d. Date of deli Month	Day Year					
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	law requires that the death certifica as seen signed by the attending ph 2 should be detached for use as th	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. THYROID CANCER		acco use contribute to s 2 □ No 3 □ Pro	the cause of death?					
COL	w requ	ietec	ININOID OMIGIN	24a. Was ar		topsy findings available					
Re	The la ate has page 2	Completed		autopsy perform 1 X Yes 2	ned? death?	ompletion of cause of 2 No					
Vita	ician: sertifica ector,	Be	avaminar?	th (Check only one							
of	Phys or this oral dir	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	ome 5 Reside 28d. Describe ho		ify) AT SCENE					
noi	anding lath. or: Afte	atlo	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No								
Division of Vital Records,	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Ru i, State)	ral Route Number,					
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place								
	the Ho iin 24 I the Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.								
	To To con	Σ	29b. Signature and title of certifier 29c. License number OCME		9d. Date signed <i>(Montl</i> MARCH 5,						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		-						
_			LING LI. M.D 111 Penn Street, Balti	imore, Ma	ryland 212	01					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrary Signature MAR 0.8 2004								

D	1012		For State Registrar	State of Marylan	d / Depa <i>Cer</i>	urtment of H tificate of L	ealth and Death	Mental Hyg	giene 20	04	09686	
I	Physici	an	1. Decedent's Name (First, Middle, Last)		Sul	livan		2. Date of Dea Month	3, Day 2004	Year	3. Time of Death 0535 P M	
	/Medic	al	Daniel 4a. Facility Name (If not institution, give	Joseph	Sur.	4b. City, Town, or	Location of Deat					
	Examin	er	Clara Barton				John					
4	Funeral Director		5 Social Security Number 6. Sex		last birthday) Yrs.	If Under 1 Year Months Days			, ref 921		llece (State or Foreign Sachusetts	
	Du .		Usual Residence of Decedent 10a. State 10b. County	10c Cih	y, Town or Lo	cation				1	0d. Inside City Limits	
	Maryla f sho	ō	MD Montgome		Cabin						12 Yes 2 □ No	
	r 28a	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cour	ntry?	
	th with	al D	7800 MacArthur	Blvd.		2081			USA			
920	should be filed within 72 hours after death with the Maryland to Mental Hygiene. marked other then "natural; or Itame 23a or 28a-f show imatic event, the Medical Examinating the notilled at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1949 Year or Dates:	- 1	Vas Decedent of Hi f Yes, specify Cuba I ☐ Yes 2X No	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - Americ ck, White, y: Wh		
2	72 ho	eted	15. Decedent's Edu (Specify only highest grade		16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation furing most of wo	rking	16b. Kind of B	usiness/Ind	dustry	
121	within ane. Ihen	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired Attorney			Group	o He	alth Asso.	
Maryland 21215-0036	al Hygi I other	Be	17. Father's Name (First, Middle, Last) Michael Sulliv	5+ an			18. Mother's Na	me (First, Middle, Walsh				
Mary	2 a 2 a	To	19a. Informant's Name/Relationship (Ty) Beverly Marster	no Print)	19b. Mailin	g Address (Street a	and Number or Ri	ural Route Number	r, City or Town, Cabin	State, Zip Joh	Code) n, Md20818	
	1 and 2 Health tem 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			20c. Location -			
Ē	Pages ment of the ant: If its		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Speckly)	emoval from State		natory or other plac ake Crei		0/04	Belts	vill.	e,Md	
Baltimore,	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	/	P 9	Name and Address HILIP D	RINALD	I FUNER	AL SER	RVICI	E,P.A. g,Md20910	
Н			23a. Part1. Enter the disease, or complishock, or head failure. List only or	cations that caused the death							Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	HULTIPLE		IRLES					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):							
		e	if any leading to immediate	Due to (or as a consequ	uence of):					+		
	tate be executed obysicien and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
8760,	oe exe cien al ourial-t	Ex	resulting in death) Last	Due to (or as a consequ	uence of):							
687	physics the b	dicai										
Box 6	death certificate be executed e attending physicien and od for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of pregna		Totania arangan			23d. Dat	te of delive	ory	
	ne death the atte	Physician/Med	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		Ectopic pregnancy Other (specify)			Мо	nth	Day Year	
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ဝင္ပ	re law requir has been s ge 2 should	Completed						24a. Was a	sv r	prior to con	psy findings available impletion of cause of	
Ž	T ate	Сош						perform 1 28-Yes	med? c 2 □ No 1	death? 1 🗷 Yes	2 No	
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Division of Vital Records,	F F F	on: To	1 XYes 2 No	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe ha	ow injury occurr	red	BY CAR	
<u>sio</u>	Attending as death. actor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	3/3/04	5!2		Yes 2 No	28f. Location (Si				
$\overline{\underline{N}}$	Dist.	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	()	set, factory, office		City or Tow	n State)		ABIN DKN, KO	
	To the Hospital within 24 hours a To the Funeral I completely filled	edical C		sician: To the best of my knowner: On the basis of examinat and manner stated.								
	To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed	d (Month, I	Day, Year)	
	6		> aueIL	_		O.C.	M.E.	ı	March 4	, 200	4	
•	G		30. Name and address of person who co	MB10, MD		Print)	Street,	Baltimor	e, Mary	land	21201	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 2004	32. Registrar's Signa	ture	Sparks	/					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) Herbert H. STEIN March 8, 2004 2:00 PM 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth Takoma Park If Under 1 Year | If Under 24 Hrs. | 8, Do Washington Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours Months Days 10XM 20 F 78 June 27, 1925 122-26-8011 Germany Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 1 ☐ Yes 2 ☑ No Maryland Prince Georges <u>Adelphi</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 1915 Ruatan Street 20783 United States 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Yeer or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Plant Manager Plastics 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Stein Charlotte Blank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1806 Kimberly Road, Silver Spring, MD Claudia Donnelly, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 10 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, VA 22. Name and Address of Facility Torchinsky Hebrew Funeral Home, Inc. 21. Signature of Fune al Service License 254 Carroll St., NW, Washington, DC 23a. Part 1 Epper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Embolus Pulmonary Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Due to (or as e consequence of) the cause of death? bably 4 Unknown ere autopsy findings ailable prior to mpletion of cause death? JYes 210 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer deeth v Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Madical Exercises.

Baltimore, Maryland 21215-0020

Directo

Funerai

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Completed

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Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the ettending physicien end completely filled in by the innertal director, page 2 should be deteched for use as the buriel-transit ed by the ettending physicien end deteched for use es the buriel-trensit þ Be Completed Medicai Certification: To

Division of Vital Records, P.O. Box 68760,

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Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given	in Part I.	23b. Did tobacco use c	ontribute to
Hypertens	NUM			1 ☐ Yes 2 ☐ No	3 🗆 Prot
/ '	Vasimla	r Dise	or Se.	24a. Was an autopsy performed?	24b. We ava
				1_ Yes 2000	10
25. Was case referred to medical			26. Place of Death (Ch	eck only one)	
examiner?	Hospital: 1 ☐ Inpatient 2 ER/O	utpatient 3 DOA Other	4 ☐ Nursing Home	5 ☐ Residence 6 ☐ Ot	her (Specify
7 Manner of Brooth				Describe how injury occur	

1 Yes 2 No	1 Li Inpatient 242	EH/Outpatient 3L3	DUA 4 Nursing F	fome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, street, fact	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
				s, and due to the ceuse(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
20h Signature and title of certifier	24-10-2	11/12 (11)	9c. License number	29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) 1 0 2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

32. Registrer's Signature

290. License number

290. License number

290. Date signed (Montin, Day, Tear)

3/4/07

(Item 23e) (Type, Print)

Washy for Adventish Itugn Falcoma Paril

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 For State

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			Registrar			Cei	rificate d	or De	atn		Reg. No.	_ ,	0 2 0 0		
			1. Decedent's Name (First, Middle, Last,)						2. Date of Dea			3. Time of Death		
	Physic		Thomas Hugh MacLeo	d Cton	haush					Month	Day	Year	M		
	/Medi		4a. Fecility Name (If not institution, give				45 City Taylor		diam of Decade	March 3, 2004 11:40					
	Examir	ner	4a. Fecility Name (if not institution, give	street and nu	imber)		4b. City, Tow	n, or Loca	ation of Death		4c. (County of Death			
			Suburban Hospital				Bethes	da				lontgome	* 37		
	Funeral		5. Social Security Number 6. Sec		7. Age (In yrs.	. last birthday)	If Under 1 Ye Months Da		Inder 24 Hrs. ours Min.	8. Date of Birt	ר	9. Birthp	lace (State or Foreign		
~	Director		578-40-2061]M 2□F	79	Yrs.	Months Da	ys no	ours Min.	June 18			sylvania		
	7		Usual Residence of Decedent							ounc it	79172	. 4 1 e i i i	Syrvania		
	lanc		10a. State 10b. County		10c. C	ity, Town or Lo	cation					1	0d. Inside City Limits		
	Aary Sh	ŏ	36 1 1 36										1 ☐ Yes 2 ☑ No		
	88a-	Sct	Maryland Montgomery Rockville												
	or 2	Director	10e. Street and Number				10f. Zip Cod	8			10g. Citize	en of What Coun	itry?		
	h w 23a	<u>=</u>	14015 Drake Drive				2	0853			11	I.C. A			
	dea me	Funeral		12. Was Dec	edent Ever in U	J.S. 13. V			ic Origin? (Spe	ecify Yes or No- Rican, etc.)		SA 4. Race - Americ	an Indian.		
	fler its	Ē	1 ☐ Never Married 2 ☑ Married	Armed Fo		'	f Yes, specify C	uban, Me	exican, Puerto	Rican, etc.)	i	Black, White,	etc.		
21215-0036	rs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 ∰ Yes If Yes, Gi Year or F			1∐Yes 2⊠i	No Sp	ecify:		5	Specify:			
Ş	72 hours after death with the Maryland natural', or itams 23a or 28a-1 show deal Exeminar must be notified at	b	15. Decedent's Edu		Dates: WW I	1	tamba Harri Or					Whi			
Ċ	n 72	Completed	(Specify only highest grade	completed)		(Give	lent's Usual Oc kind of work do OO NOT use rei	ne during	most of worki	ing	16b. Kind	d of Business/Ind	dustry		
2	Athir	du	Elementary/Secondary (0-12)	College (1-4or 5+)	lire. L	OO NOT use ret	tired)							
N	digies of v	8		2		Optic	ian & M	anao	er		Е	ve Care			
ğ	E H	Be (17. Father's Name (First, Middle, Last)			•		18.1	Mother's Name	(First, Middle,					
ā	d b ents ked	To	Samuel Grover Stam	hauch				3.6			_	_			
2	hou d M mar mat	1	19a. Informant's Name/Relationship (Ty)			10b Mailin	n Addense /Ctm	M	yrtie M	Marie Ma	cLeo	d Town, State, Zip			
Maryiand	12 s h an 7 ls reu					130. Mailli	y Address (Sire	sel allu iv	umber or mura	II Houte Number	, City or	iown, State, Zip	Code)		
45	and ealt m 2		Frances S. Stambau	gh W	ife	14015	Drake	Driv	e Roc	kville,	Mar	yland 20	353		
56	of H		20a. Method of Disposition		_ ! !	cemetery, cran	sition (Name of natory or other p	olaca)	, D			ation - City or To			
Ĕ	S = = 50		1 XBurial 2 ☐ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emovai from	State Arl	ington.	Nation	al í			secondary of				
	arta artini		21. Signature of Funeral Service License	96	T	22	etery . Name and Ad	drose of F					/irginia_		
Baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show amportant: If item 27 is marked other than "natural", or itams 23a or 28a-f show amportant: If item 27 is marked other transfer to notified at once.		211041			Fra	ancis J	 Co. 	llíns F	uneral	Home	. Inc.			
			1 Juland L States				J Unive	rsit	y Blvd.	.W.,Sil	ver	Spring,	D_{20901}		
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that one	caused the deat	th. Do not ente	er the mode of o	tying, suc	ch as cardiac o	r respiratory arr	est,	1	Approximate Interval Between		
	Physician	Immediate Cause (Final									Onset and Death				
•	/Medical		disease or condition resulting in death)		TITYU	ru	111001	101	YIUTT	IU Y			24		
	Examiner		4	Due to	(or as a consec	(uence of):				-			1		
		_	Sequentially list conditions b												
	o	ine	if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	luence of):									
	cute	Examiner	Cause (Disease or injury that initiated events												
Ď.	exe In all ial-t	EX	resulting in death) Last	Due to	(or as a conseq	ruence of):									
٥	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ā													
68/60,	phy phy the	n/Medical	0												
ŏ	ertif ling e as	Me	IF FEMALE:												
9	th c		23b. Was decedent pregnant in the past 12 months?	4 🗀	tcome of pregna pirth 2 Peta	ancy Il death 3□	Ectopic pregnar	ncv			230	d. Date of deliver			
-	dea ne al	Sici	1 ☐ Yes 2 ☐ No		nant at time of d	leath 5	Other (specify)					Month I	Day Year		
j.	t the by th achie	hys	9 Unknown	9LJ UNKN	OWN										
7	ires that the death signed by the atte I be detached for	by Physicia	Part II. Other significant conditions con	tributing to d	eath but not res	ulting in the un	derlying cause	given in F	Part I.	23e. Did toi	acco use	contribute to the	cause of death?		
2	sigr sigr d be		advanced 5							100	s 2 🗀 i	No 3 ☐ Proba	bly 4 Unknown		
0	w require been si should I	tec	and an a	1 17	4,00	0170	20110			1014			oly 4 Dikriowit		
Kecords,	law asb 2 sl	Completed								24a. Was a		24b. Were autop	sy findings available		
_	The te h age	ОП								autops	ned?	death?	pletion of cause of		
0	iffica or, p	e C	25. Was case referred to medical								No No	1 ∐ Yes :	200		
>	Attanding Physicien: If death. actor: After this certifice by the funeral director, p	8	examiner?	ospital:	,		10	Othor		(Check only on					
Ö	this aldi	ို	10 105	1 🗙	•	ER/Outpatient	3□ DOA	4		ne 5 🗆 Reside		Other (Specify)			
=	fter fter iner	0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date (Mon	th, Day Year)	28b. Time of Injury	28c. In	jury at /ork?	2	8d. Describe ho	w injury o	occurred			
<u> </u>	andi ath.	ati	2 Accident investigation				M 1	☐ Yes	2 □No						
DIVISION OF VITAL	Atte	ij	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At he	ome, farm, stre	et, factory, offic	ө	2	8f. Location (St	reet and A	Number or Rural	Route Number.		
5	after after Dira	Certification:	4 Homicide	buildi	ng, etc. (Specif	<i>y)</i>	•			City or Town	, State)	-			
	pita ours eral		29a. Certifier Certifying Phys	inion. To the	h t										
	Hos Fun Bely	ica	(Check only 2 Medical Examin	er: On the b	asis of examina	wiedge, death tion and/or invi	occurred at the estigation, in my	time, dat opinion	e and place, a death occurre	nd due to the ca	iuse(s) an	nd manner as sta	ted.		
	To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2	Medical	,	and man	ner stated.						and ph		vause(s)		
		2	29b. Signature and title of certifier			0 00	29c. Lice	nse numl	ber	25	d. Date s	igned (Month, D	ay, Year)		
1	0		VVIVM Oa A	MA	NKII	WIL	A A	NG	Nan	7	2	19/10	[
,	7		30. Name and address of person who cou	mnlated co	o of docth /li-	230) (7	- V	V	176	-	1	1010			
			Melissa Means-Mark			3600 01	d Georg	etow	n Road	Bethes	da.M	aryland	20814		
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa	ture /		0 .							

DHMH 17 Rev 1/2001

MAR 08 2004

Registrar

3)3104 2340pm

Stambaugh, Thomas

oaks

	1 - For State Registrar			C	ertificate of	Death		Reg. No.		T
Physician /Medical	1. Decedent's N	ame (First, Middle, e11e	Baird	s	prague		2. Date of De Month March	Day	^{Үөөг} 04	3. Time of Death 6:10 A
Examiner Funeral Director	Carria 5. Social Securit 015-26-	age Hill 1 y Number 6 -0947	give street and number Nursing Hom Sex 7. Aq 1□ M 2 PF		Bethe		8. Date of Bir	th	tgome 9. Birthp Coun	ery lace (State or Fore try)
Maryland	Usuel Residence 10a. State Marylai	10b. County	omery	10c. City, Town or Bethes					1	0d. Inside City Limi 1 ☐ Yes 2 ☑ N
3a or 28	10e. Street and 4925	_{Number} Battery I	ane		10f. Zip Code	0814		10g. Citizen of V	What Coun	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. Important: If lem 27 is marked other than "natural" or items 23a or 28a-f show many njury or other treumatic event, the Modical Executive nates the notified at any njury or other treumatic event, the Modical Executive nates the notified at any njury or other treumatic event, the Modical Executive nates and native any native nativ	3 ☐ Widowe	is Iarried 2⊡ Married d 4. XX Divorced	12. Was Decedent Armed Forces' d 1 Yes 2 If Yes, Give A Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	dispanic Origin? (S an, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)	5 14. Rac Blac Specify	e - Americ ck, White, /: Wh	
ed within 72 houygiene. Ser than "naturality if the Modical Et. To modical Completed	(S Elementary/S	15. Decedent's pecify only highest econdary (0-12)	Education grade completed) College (1-4or	5+) life	cedent's Usual Occup ive kind of work done s. DO NOT use retire Pro	king	16b. Kind of B	usiness/Ind	-	
nould be filed within a Mental Hygiene. narked other than natic event, than a To Be Comp	17. Father's Na	me (First, Middle, La				18. Mother's Nan	ne <i>(First, Middle</i> abeth	, Maiden Surnan		
and 2 should leath and Men n 27 is marke ler treumatic	19a. Informant	s Name/Relationships Baird Sp	ship (Type, Print)		ailing Address <i>(Street</i> 51 Indian			-		
Pages 1 and of Hecon of Hecon of Hecon of Hecon of Hecon of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon or of Hecon	20a. Method of Disposition 1									
permit. Deportm Importa any nju	1	Funeral Service Li	censee	401261	933 Gist	eral and Ave., Si	lver_Sp	ring, M	ices 120	910
law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit application. Place of the property of th	Immediate Cat disease or con resulting in dea Sequentially lis if any, leading cause. Enter to Cause (Diseas that initiated ev resulting in dea	t conditions, o immediate nderlying o or injury ents	bDue to (or as	Tumor Unki s a consequence of): s a consequence of):	nown Etiol	ogy				Onset and Death 3+ Mont
res that the death certify igned by the attending to be detached for use as by Physician/Me		12 months? 2 XNo			3 □Ectopic pregnanc 5 □ Other (specify) _	у			te of delive	ry Day Year
w requires that been signed b should be deta	Part II. Other si	gnificant condition	s contributing to death	but not resulting in th	e underlying cause give	ven in Part I.		tobacco use cont		ne cause of death?
ate h							24a. Was auto perfe 1 \(\text{Yes} \)	psy ormed?	Were autop prior to cor death? 1 Yes	psy findings availa npletion of cause of 2 No
ital or Attending Physician: The Is after death. sale discolor: Atter this certificate ha led in by the funeral director, page? Certification: To Be Comp	examiner?	Death 5 Pending nt investiga 6 Could no	ot be 28e. Place of Ir	ury 28b. Tim	a of y Wo		lome 5 ☐ Resi 28d. Describe	one) idence 6 Oth how injury occur Street and Numb	red	
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only		Physician: To the best	of examination and/o						
To the within 2 To the complete	29b. Signature	and title of certifier	and manner s	tated.	29c. Licens	se number 5579		29d. Date signe March		
10		address of person w	no completed cause of							

Registrar

State of Maryland / Department of Health and Mental Hygiene

		Colate of Waryland / Dep	ertificate of		, ,	g. No. 201	IL nacar
	Physician	1. Decedent's Neme <i>(First, Middle, Last)</i> Mabel Coleman	Smith	2	2. Date of Deeth Month March	2 Dey 2004 Year	3. Time of Death 2:24 PM
	/Medical Examiner	4a Fecility Neme (If not institution, give street and number)	Jan 2 Cir	4b. City, Town, or Loca		4c. County of De	
	Examine	Ft. Washington Hospital		Ft. Wash:	_	Prince	e George's
	Funeral Director	5. Social Security Number 225-52-4141 6. Sex 1 M 2 N F 86 Yrs.	y) If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, ec 26,	Year) 9. B 1917 V	irthplace (State or Foreign Country) irginia
	Mo man	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or I	Location				10d. Inside City Limits
	Mary a-f sh red	MD Prince George's Oxon Hi	i 11				1 □ Yes 2 □ No
	or 28	10e. Street end Number	10	g. Citizen of What C			
	wher death with the Marriems 23s or 28s-1s. Infer most be notified. Funeral Director	2109 Alice Avenue Apt. 1 11. Maritel Status 12. Wes Decedent Ever in U.S. 13	Hispania Origina (Smaai	fy Von ou No	USA	nerican Indian,	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1 Never Married 2 Married 1 Ves 2 No If Yes Crown Year or Dates:	If Yes, specify Cub	Hispanic Origin? (Speci pan, Mexican, Puerto Ric Specify:	can, etc.)	Black, Wh	
5	be filed within 72 hours et al Hygiene. d other than "natural", o event, the Medical Exam Be Completed by	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occu	pation during most of working	1	6b. Kind of Busines	s/Industry
12	within sne.	Elementary/Secondary (0·12) College (1·4or 5+)	DO NOT use retire	id)		Halifax C	•
<u>5</u>	Hygin of the office of the off	17. Fether's Neme (First, Middle, Last)	COOK	18. Mother's Name (#		School Bo aiden Sumame)	ard
<u>ya</u>	Menta Menta Menta Mitic ev To B	Charlie Henry Coleman		Bettie	Logan		
Mar	12 short and is many in a			t and Number or Rural F			Zip Code)
ē,	1 and Healtl em 27 other 1		36 Beechwoosition (Name of ematory or other pla	ood Drive N		• MD Oc. Location - City o	r Town State
Ē	Peges nt: If if		ematory or other pla Baptist C		6/04	•	
alti	mit. ppartm porta y inju			ess of Facility Ineral Home		Java, Vi	rginia
10	80 E 8 9	Deposer Juent	P.O. Box	423 Gretna	a, Virg	inia 2455	7
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on eech line.	nter the mode of dyi	ng, such as cardiac or r	espiratory arres	st,	Approximate Interval Between Onset and Death
1	Physician /Medical	Immediate Ceuse (Final					
ć.	Examiner	disease or condition resulting in death) Myocardial Infa					Immediate
	sit sit	Hypertensive He	eart Disea	ise			
	rificate be executed ng physician end set the burial-transit Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c	equence of):				
68760,	ysicia ysicia ne buri	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e conse	equence of):				
9 ×	e es ti	d.					
ROX	attend for us		-				1
л Э	nat the death ce d by the attendir leteched for use Physician/P	Part II. Other significent conditions contributing to death but not resulting in the	underlying cause gi	en in Part I.			e to the cause of deeth? Probably 4 Unknown
ς, Τ	es that igned I be det	Obesity			1 103	2L NO 3 F	Tobably 4 Olikilowii
Vital Records,	been s should	Arthritis			24a. Was an performe	autopsy 24b.	Were autopsy findings available prior to completion of cause of deeth?
屈	cate h			10	1 ☐ Yes	2X No	1 ☐ Yes 2 ☐ No
	Physiclan: rthis certific ral director, r. To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 → No Hospital: 1 ☐ Inpatient 2 → ER/Outpatie	Oth	26. Place of Death (C			
0	a Physical distriction	27. Manner of Death 28e. Date of Injury 28b. Time of	SIII SLI DOA	4 LI Nursing Home		ce 6 GOther (Spe injury occurred	∍cify)
201	Attending or death. octor: After by the fune liffcation	2 ☐ Accident investigation		Yes 2 No			
DIVISION	tal or Attending P rs efter death. al Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f.	Location (Stre City or Town,	et and Number or R State)	ural Route Number,
		29a. Certifier 1∑ Certifying Physician: To the best of my knowledge, deat	th occurred at the tir	ne, date and place, and	due to the cau	se(s) and manner a	s stated
	he Hospi in 24 hou he Funer pletely fil	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my o	pinion, death occurred a	at the time, date	and place, and du	e to the cause(s)
	To the within 2 To the complex	29b. Signaturé and title of certifier	29c. Licens			. Date signed (Mon	
	\$	20 Name and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of assess who was the same and address of a same and a same and a same and address		01012326	71	March 3,	2004
		30. Name and address of person who completed cause of death (Item 23e) (Type, Manolisa-Cornel, MD 5249 D		t Alexadnri	ia, VA 2	22304	
Ш	State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature					
	Registrar	MAR 12 2004 Shewa	Sporks				

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of F <i>tificate of</i>		ental Hyg ا	giene Reg. No. 2 (004	09691
	Physici	an	Decedent's Name (First, Middle, Last) FREDERICK	C. 5	SIMPSON			2. Date of Dea Month	ath Day	Yeer	3. Time of Death
	/Medic Examin		4a. Fecility Name (If not institution, give s		311/P30/N	4b. City, Town, o	or Location of Death	MARCH		2004 nty of Death	14:25 M
		•	Montgomery Genera	1 Hospital			ney		r	Montgo	mery
	Funeral Director		007 18 7663	M 2□F	(In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day May 12	h v. Year) 1925		lace (State or Foreign try) Ine
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				11	0d. Inside City Limits
	Maryl -f sho	tor	Md. Mont	gomery	Derwo	od					1 ☐ Yes 2 KNo
	th the	irec	10e. Street and Number	30	201 110	10f. Zip Code			10g. Citizen o	f What Coun	try?
	ath wi	ral	18705 Rocky Way				8 5 5			ed Sta	tes
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at once.	y Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: V		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 ♣No	dispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ri Bi	ace - Americ lack, White, o	etc.
5-0036	2 hour	ed b	15. Decedent's Educ		16a. Deced	ient's Usual Occup	ation		16b. Kind of		White
215	hin 72 9. Medii	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+	(Give	kind of work done OO NOT use retired	during most of work	ing	100.11110	544 III 644 III 6	
2121	ygien ygien yer tha	Соп	12	4		hanical	Engineer			Depar	tment
aryland	ntal H ed oth	Be	17. Father's Name (First, Middle, Last) Frederick Thoma	s Simpso	\n		18. Mother's Name	e <i>(First, Middl</i> e, Campl		ame)	
Ž	should nd Me mark smatic	ĭ	19a. Informant's Name/Relationship (Typ			a Address (Street	and Number or Rura	· · · · · · · · · · · · · · · · · · ·		n. State. Zio	Code)
S S	alth ar 27 is		Arna R. Simpson /	Wife			Way, Derw			208	_
altimore,	of Her		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		20b. Place of Dispos cemetery, crem	sition (Name of natory or other place	(80	Date	20c. Location		
Ĕ	ment tent: Pag		'4 □Donation 5 □ Other (Specify)	sinovai noni State	All Soul	s Cemeter	ry 3/	9/04	Germar	itown,	Md.
Ball	permit Depart Import any in		21. Signature of Funeral Service License	HBa	alu 22	Muriel H P. O. Bo	ss of Facility Barber ox 5038, I	Funeral Laytons	Home	Md. 2	0882
No.			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the cause on each line	ne death. Do not ente	er the mode of dying	ng, such as cardiac o	or respiratory arr	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Cardo	ac Asra	st				6	Onset and Death
×	Examiner			Due to (or as a	consequence of):	and al	- 1 1				to recore
	1	Jer	Sequentially list conditions, b	Due to (or as a	consequence of):	J. are	of due	are			io jeus
	nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	·							
60,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
68760,	ificate be executed g physician and as the buriat-transit	edlcai	d								
Box	at the death certiful by the attending parached for use as		IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of	pregnancy				23d. D	ate of deliver	v
	death ne atte	Physiclan/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown		Ectopic pregnancy Other (specify)	'		М	onth I	Day Year
0.0	d by the	Phys	9 Unknown					1/42			
rds,	The law requires that the te has been signed by thoage 2 should be detached.	by	Part II. Other significant conditions con	tributing to death but	not resulting in the un	iderlying cause givi	en in Part I.				bly 4 Unknown
000	aw require is been sig 2 should b	Completed						24a. Was a	n 24b.	Were autop	sy findings available
Ĕ		Com						autops perfori	med? 2 No	prior to com death? 1 \(\text{Yes} \)	pletion of cause of
/ita	ician: sertific actor,	Be	25. Was case referred to medical examiner?		/		26. Place of Death				
0	Physic this cral dir	2	1 ☐ Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of		4 Nursing Hor				
o	ding F th. : After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(ear) Injury	28c. Injun Worl	γαι k? Yes 2 □ No	28d. Describe ho	ow injury occu	rred	
Division of Vital Records,	or Attenditer deall Director; in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	et, factory, office	-	28f. Location (Si City or Town		ber or Rural	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Medical Ce	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	er: On the basis of e	xamination and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ca	ause(s) and mate and place,	anner as sta	ted. the cause(s)
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner state	d.	29c. License			9d. Date signe		
	17/1		· Retypelle			D 33	067		13/06	- /	,
	\-v		30. Name and address of person who cor	npleted cause of dea		Print)				1	
			Robert Gallins	18100	1 Prince	Philip	Drive	CINEY	MX	208	32
1	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	Sparks	1				

Nanor Care Potomac Potomac Potomac Social Security Numbers S. Sext Sext Nanor Sext Sext Sext Nanor Sext	004 0969		
Manor Care Potomac Security Number 6. Sax Sax System S	3. Time of Death 10:45 P		
United U	ntgomery 9. Birthplace (State or Foreign Country) Pennsylvania		
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Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Ow.	ace - American Indian, lack, White, etc.		
Howard Bloom Howard Bloom	Business/Industry n Home		
Gary Abramson, Nephew 11501 Huff Court, N. Bethesda, MD	ess		
Comparing Comp	20895 n - City or Town, State		
Physician / Medical Examiner Physic	Church, VA		
Due to (or as a consequence of): Due to (or as a consequence of):	, DC 20012 Approximate Interval Batween Onset and Death		
The state of the s	e WIE YRS.		
1 Yes 2 No 24a. Was an autopsy performed? 1 Yes 28 No	Date of delivery Month Day Year		
24a. Was an 24b autopsy performed? 1 □ Yes 2 28 No	ntribute to the cause of death? 3 ☐ Probably 4 ŒUnknown		
U 25. Was case referred to medical examiner? O 1 1 1 98 2 2 No. Hospital: 1 Inpatient 2 FR/Outnatient 3 DOA Other: 4 2 No.	Were autopsy findings available prior to completion of cause of death? □ Yes 2		
= 2° = 6 1 (ZrNatural 5 □ Pending (Month, Day Year) Injury Work?			
3 Suicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4	nber or Rural Roule Number,		
	e, and due to the cause(s)		
3(4) D35792 MARC	29d. Date signed (Month, Day, Year) MARCH, 8, 2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar A Abanks	or, Kockvia		

			1 - For State Registrar	State of Ma	ryland / D	epartment of Certificate of	Health and	Mental Hyg	ene 20	e. 04 09693
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last Meliton	Sef	erino			2. Date of Death Month March	4,2004	
	Exami	ner	4a. Fecility Name (If not institution, give Shady Grove Adv		ospita		or Location of Dear Ville	th	4c. County of Montg	omery
	Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 15 0 68-82-5220 Usual Residence of Decedent	211 00 5	(In yrs. last birth	nday) If Under 1 Year Months Days			9 6 6 1	Birthplace (State or Foreign Country) Mexico
	e Maryland la-f show	ctor	10a. State 10b. County MD Montgom	ery	10c. City, Town Rockv					10d. Inside City Limits 1 ☐ Yes 2 💆 No
	3a or 28	I Director	10e. Street and Number 1102 Thornden R	oad		10f. Zip Code 208	351	10	g. Citizen of Wha	•
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show sumatic event, it as Medical Evaporate must be notified at	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Amed Forces? 1 □ Yes 2 反 No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cub			Black, \	American Indian, White, etc. White
Maryland 21215-0036	within 72 ho ene. than "natura	ompleted	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+	+)	Decedent's Usual Occu Give kind of work done life. DO NOT use retire Unemploye	rking	6b. Kind of Busin	ess/Industry	
		BeC	17. Father's Name (First, Middle, Last)			anomp201		me (First, Middle, M	aiden Sumame)	
<u> </u>	Ment Ment Marked Marked Marked	10	Sabino Baldes					ina Gar		_
Mar	and 2 sh alth and 27 is m ar traum		19a. Informant's Name/Relationship (Ty Guillermina Pon		r 11	Mailing Address (Street 02 Thorno	and Number or Au len Road	ral Route Number, Rockvi	City or Town, Sta lle, Md	10. Zip Code) 20851
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked, any injury or other traumatic evone.		20a. Method of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Speetly)	emoval from State	20b. Place of Commetery Tilza	Disposition (Name of crematory or other plate Portla	^{ce)} 3/12		oc. Location - City Morelos	or Town, State S, Mexico
Balt	Departi Departi Importi any inj g0008.		21. Signalur A Funeral Service Licens	Z		PHTLTP ^{ddf} 9241 Col	RIWALD Lumbia E	FUNER	AL SERV	/ICE,P.A. ing,Md20910
T A	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Pulmenar	the death. Do not	reulosis	ng, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death Wouth
/60,	ate be executed xx xx xx xx xx xx xx xx xx xx xx xx xx	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of					
O. Box 68	Ine law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	4		23d. Date of Month	delivery Day Year
rds, r	w requires that the de been signed by tha a should be detached	by	Part II. Other significant conditions con Pueumothorax	tributing to death but	not resulting in t	he underlying cause giv	ren in Part I.	23e. Did toba		e to the cause of death? Probably 4 Unknown
		e Completed	25 W.					24a. Was an autopsy performs	prior	a autopsy findings available to completion of cause of h? Yes 2 \(\) No
IO TO HOI	To the hospite or Attending Physician: within 24 hours after death To the Funeral Director: After this certifica completely filled in by the funeral director.	To B	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day)	28b. Tin	ne of 28c. Injur	er: 4 Nursing H	th (Check only one) ome 5 Resident 28d. Describe how		Specify)
DIVISION	s after des s after des at Directo ed in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm (Specify)	, street, factory, office		28f. Location (Stre City or Town,	et and Number or State)	Rural Route Number,
:	e Hospi 124 hour se Funeri vetely fills	edical (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exemination	sician: To the best of ner: On the basis of e and manner state	xamination and/	death occurred at the tir or investigation, in my o	ne, date and place, pinion, death occur	and due to the cau rred at the time, date	se(s) and manner and place, and o	r as stated. due to the cause(s)
;	vithir To th comp	Me	29b. Signature and tyle of certifier			29c. Licens			. Date signed (Me	
	1		30 Nema and addition	MD	AL //A- 05 : =		5\$117		rch 4,	2004
			30. Name and address of person who con Eric J. Park 9901			rive, Rocker	le, ud 2	0850		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 8 2004	32. Registrar		Sparks	/			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2004 **Physician** 4, Mar. 12:11 am Marian Lobban Sawtelle /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, You Mar. 16, 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months Days Hours 1 □ M 2 🖾 F 49 Yrs ~1954 219-68-6807 Washington, DC Director Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at tXYes 2□No Hyattsville Director Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20781 USA 5610 39th Avenue Funeral filed within 72 hours efter death v Hygiene. ither then "natural", or items 23 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Business Manager Department of Health and Mental Hygis Important: If them 27 ie marked other I any injury or other traumatic event, II once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Pearl Harris Floyd G. Lobban 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5610 39th Avenue, Hyattsville, MD 20781 Bruce Alan Sawtelle - spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State George Wash. Cemetery 3/8/2004 Adelphi, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licansee 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the deeth certificate be executed attending physician end for use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 水 ☐ Unknown been signed to should be det þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 L Y58 21 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA After this I Director: After this od in by the funeral of 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 Yes 2 No death. investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide efter To the Hospital o within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ad address of person who completed cause of death (Item 23a) (Type, Print) Ze pull 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 8 2004

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month ANDRE SUMMERS 2232 P M FEBRUARY 28, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL GENERAL HOSPITAL ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. DEC 13 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 220 13 1195 1 M 2 □ F 31 Year) Director Yrs. 1972 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show the Medical Examiner must be nutified at P.G. MD. BOWIE 1 XYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3500 EMPEROR COURT 20721 238 USA death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. fited within 72 hours after 1 Yes 2 No Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify BLACK 3 Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 1 2 COMPUTER TECHNICIAN PVT. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Pages 1 and 2 should be FRANK SUMMERS JR. YVONNE WHITMYER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu FRANK SUMMERS JR./FATHER 13217 VANDINE ST., UPPER MARLBORO MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State HARMONY MEM. PARK 3/9/04 LANDOVER MD. * 4 ☐Donation 5 ☐ Other (Specify) 21. Sign tu e of Fune al Service Licensee 22. Name and Address of Facility WATSON F. H. 3435 14th ST., N.W. WASH. DC 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) wound of chest **Physician** Gunshot /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death Day 5 Other (specify) ed by the a detached f O 9□ Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? page director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 【XDOA 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 28/04 1 ☐ Yes 2 XNo subject was shot investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide outside residence 2057 Lake Grove Ln. Crofton, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier mpletely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 1, 2004

State Registrar

111 Penn Street, Baltimore, Maryland 21201 ANA RUBIO, MD 32. Registrar's Signature

30. Inamid and address of person who completed cause or death (non-soa) (type, fining

			1 - For State Registrar	State of	Maryland		artment of Hertificate of E			ene . No. 200	L 19696
	Division		1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Media			1or					March	7 2004	1 200 2
	Examir	er	4a. Facility Name (If not institution,	-	nber)		4b. City, Town, or			4c. County of Dea	
			Manor Care 5. Social Security Number		7. Age (In yrs. la	st hirthday)	Lat	rgo If Under 24 Hrs.	8. Date of Birth		George's
	Funeral Director		578-16-8793	1X M 2□ F	84		Months Days	Hours Min.	Jan. 30,		ush., DC
	D		Usual Residence of Decedent							2,20,	
	anylar show	_	10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M	Director	D.C. 10e. Street and Number					shington	140-	077	
	with a or 3			ت بدات است.	יזי		10f. Zip Code	0020	100	. Citizen of What Co	•
	ns 23	era	1717 Frankfo	12. Was Dece	dent Ever in U.S	i. 13. V			ecify Yes or No-	United	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 TYes If Yes, Given Year or Da	2		Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2☐∰No	Specify:	Rican, etc.)	Black, Whit	te, etc. Black
5	72 ho natur	eted	15. Decedent's (Specify only highest	Education arade completed)		16a. Deced	dent's Usual Occupat	ion urina most of worki	na 16	b. Kind of Business	/Industry
2	vithin ne. han	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	`life. l	DO NOT use retired)	-			
7	iled v Hygie ther t	ပိ	12th 17. Father's Name (First, Middle, La	act)			Mail C		(First, Middle, Ma	Govern	ment
and	d be f antal h sed of	o Be		ie Tayloi	_			IO. MOLITO S INALITO	Midie C		
2	should nd Me mark matti	ို	19a. Informant's Name/Relationship			19b. Mailir	ig Address (Street ar	nd Number or Rura			Zip Code)
	alth al		Sonia Taylor -	Wife			7 Frankfo				020
altimore,	es 1 a of He of He rothe		20a. Method of Disposition	□ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □		ace of Dispo	sition (Name of natory or other place) D	ate 20	c. Location - City or	Town, State
Ĕ	Page ment a ant: If ury or		1 ☐Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spe		iaie		emorial C	l .	2004	Suitlan	d, MD
Balt	permit. Departimporti		21. Signature of Funeral Service Li	conspo Xuelai	TIL	22	Name and Address 4001 Beni		wart Fun N.E. Wa		20019
	Physician /Medical Examiner		23a. Part / Enter the disease, or conshoot, or heart failure. List of immediate 2 ause (Final disease or condition resulting in death) Sequentially list conditions,	a. Fu	tused the death. Ich line.	em	· A	such as cardiac o			Approximate Interval Between Onset and Death
38760,	ficate be executed physician and s the burial-transit	dical Examiner	if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a conseque						
Box 6	death certifi e attending ed for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		th 2 Fetal o	death 3	Ectopic pregnancy			23d. Date of del	ivery Day Year
P.O.	es that the death certif igned by the attending be detached for use a:	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno			Other (specify)				Ju, 100.
	law requires that the as been signed by th 2 should be detache		Part II. Other significant condition	s contributing to dea	ath but not resuit	ting in the ur	nderlying cause giver	in Part I.			othe cause of death? obably 4 SUnknown
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VIE V	Physician: Th this certificate ral director, paç	Be	25. Was case referred to medical examiner?	Hospital				26. Place of Death			- 4
ō	£ 5 =	T.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ In 28a. Date of		R/Outpatien 28b. Time of	t 3 DOA	4 X Nursing Hon	ne 5 Residence 8d. Describe how	e 6 Other (Specialistics)	cify)
on	ding h. After fune	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month	, Day Year)	Injury	28c. Injury a Work? M 1 🗆 Ye	s 2 □No	od. Describe now	injury occurred	
DIVIS	al or Attending s after death. il Director: After ed in by the fune	Certification;	3 Suicide 6 Could no 4 Homicide determin	and 286. Place	of Injury - At hom g, etc. (Specify)	ne, farm, stre	eet, factory, office	2	8f. Location (Stree City or Town, S	t and Number or Ru tate)	ıral Route Number,
	To the Hospital of within 24 hours af To the Funeral Completely filled in	edical (29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the la aminer: On the ba and mann	sis of examination	ledge, death on and/or inv	occurred at the time restigation, in my opin	, date and place, a nion, death occurre	nd due to the caus od at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
į	To t withi Comp	×	29b. Signature and title of certifier			MI	29c. License		29d.	Date signed (Montl	n, Day, Year)
	(10)		30. Tanna and address of person wh	no compl eted cause	of death (Item 2	23a) (Type, I		,	-		
_	·						Hanover Pl	cwy., #A,	Greenbe	1t, MD 2	0770
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 1 200	4 See	gistrar's Signatu	frey	W				
DH	MH 17 Rev 1/2	201								0.000	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Veer **Physician** Mary Edwards Turner 5 2004 /Medical March 7:39 AM 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Takoma Park

If Under 24 Hrs.
Hours Min.
March 17,1910 Washington Adventist Hospital Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** Days Months 1 □ M 2 🗓 F 93 Yrs. Director Florida 067-14-3983 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Maryland Montgomery Funeral Director Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 12001 Old Columbia Pike #702 20904 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No **Black** 1 ☐ Yes 2 ☐ No Specify: Specify Completed by 3 ₩idowed 4 Divorced Year or Dates: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) booth operator transit system 13 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James S. Edwards unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type, Print) Margaret Turner - daughter 12001 Old Columbia Pike #702, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3-10-04 Brentwood, MD 6 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. re of Funera Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 Bo not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate ba axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? urs aftar death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should 24a. Was an autopsy performed? Completed TUYUS ZUNO 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medicai Certification: To 1 Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🛣 No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Complataly filled Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) certifie, 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature end title 57131 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) PAKOMA PAGUC, MP NRW MAGUE 7600 CARROW 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 2004 Registrar MAR

			State of Maryland / Do	epartment of Health and Ment Certificate of Death	
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last) Mira Roberta Tillman 4a. Fecility Name (If not institution, give street and number) Doctor Hospital		ate of Death Day Year 9.46 A M 4c. County of Death Prince George
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. 8, Days Hours Min. (A	ate of Birth Place (State or Foreign Founts), Pay, Year) ne 3,1931 9. Birthplace (State or Foreign Vashington, I
	with the Maryland or 28a-1 show be notified at	ctor	Md Prince George 10c. City, Town	Land	10d. Inside City Limits 1 ☑ ∜es 2 ☐ No
	th with the 23e or 2	al Dire	3713 Deming Drive	10f. Zip Code 20746	10g. Citizen of What Country? USA
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artiment of Heath and Mental Hygiene. ordent: if liem 27 is marked other than "naturel; or liema 23e or 28a-1 show injuryer other traumatic event, the Medical Examinational Denotified at a	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Koe If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican □ Yes 2 XNo Specify:	(es or No- , etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
таы, МДКА Maryland 21215-0 036	d within 72 ho piene. r than "natur the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) DOK	16b. Kind of Business/Industry Private
√, √ yland 2	should be filed nd Mental Hygi i marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Robert Lambert	Clara He	
	alth and 27 is my		Juanita Jewell Daughter 3.	Mailing Address (Street and Number or Rural Rou 713 DEMING DRIVE Su	te Number, City or Town, State, Zip Code) itland, Md 20746
$\int \mathcal{I}_{\mathcal{L}_{\mathcal{L}}}$	permit. Pages 1 a Department of He Important: if item any injury or othe angle.		Laburar 2 Licremation 3 Linemovarium State	Disposition (Name of crematory or other place) ngton National	
Ball	permit. Page Department (Important: ff any injury or		21. Signature of Funeral Service Licensee	Snead Funeral Hom 5732 Georgia Ave	e & Cremation Service NW Washington,DC 20011
68760,	Iteate be executed // // // // // // // // // // // // //	edicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the cause of the ca	ubondo cardo 1 1.	Approximate Interval Between Onset and Death
P.O. Box	The law requires that the death certificate be exite has been signed by the attending physician vage 2 should be detached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
ords, P	requir	þ	Part II. Other significant conditions contributing to death but not resulting in the significant conditions.		3e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Il Rec	sician: The law certificate has t irector, page 2 s	Completed			4a. Was an autopsy findings available prior to completion of cause of death? ☐ Yes 2⊠No 1 ☐ Yes 2 ☐ No
Division of Vital Records,	this ald	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No	me of 28c. Injury at 28d. D	ck only one) GResidence 6 Other (Specify) rescribe how injury occurred
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	e Hospital 3 24 hours a e Funeral l letely filled	edical (29a. Certifier (Cneck only one) Ceneck only one) Ceneck only one) Ceneck only one) Ceneck only one) Ceneck only one) Certifying Physician: To the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of my knowledge, the centre of the best of the best of my knowledge, the centre of the best o	or investigation, in my opinion, death occurred at t	he time date and place and due to the cause(s)
	Y To the To the Comple	Me	29b. Signature and title of certifier Ko	29c. License number D Z 2 (1 / ype, Print) O G A Cen Kg 37	29d. Date signed (Month, Day, Year)
			30. Name and address of person who completed cause of death (Item 23a) (T	ype, Print)	102 Cankers MD
	Sta Registi	100	31. Date filed (Month, Day, Year) MAR 0 9 2004 32. Registrar's Signature	Sparks	

		1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of He <i>rtificate of D</i>	ealth and Me leath	ental Hygiei Reg.		09699
Physic /Med		1. Decedent's Name <i>(First, Middle, L</i> as Betty Jane	Taylor				2. Date of Death Month Iarch 5	Day 2004	3. Time of Death 4:30 Au
Exam Funera	iner I	4a. Facility Name (If not institution, give Holy Cross Hosp 5. Social Security Number 6. S	oital	e (In yrs. last birthday)	If Under 1 Year	r Spring If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Ye.	Montgome 9. Birt Co	ery hplace (State or Foreign
Directo		Usual Residence of Decedent 10a. State 10b. County		80 Yrs.		J	an. 6, 1	924	Ohio 10d. Inside City Limits
with the Mar	Director	Maryland Montgo		Silver	10f. Zip Code	0901	10g.	Citizen of What Co	-
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modell Examiner must be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☑ Yes 2 ☐ I If Yes, Give Year or Dates:	No	Was Decedent of Hisp If Yes, specify Cuban,		ify Yes or No- can, etc.)	14. Race - Ame Black, White	nican Indian,
21215-0036 d within 72 hours af giene. or then "natural; or ine W. decal Exam.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation	16a. Dece (Give	dent's Usual Occupation kind of work done during the DO NOT use retired) Crossing (ring most of working	16b	Kind of Business/	Industry
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e, Mar 1 and 2 sh Health and 9m 27 Is m ther traum		19a. Informant's Name/Relationship (7) William F. Tay1 20a. Method of Disposition	•		ng Address (Street and Of Tenbrool		lver Spr	ing, Md.	20901
altimore, mit. Pages 1 a partment of Hea portent: If Item y injury or othe)	1 Burial 2 Cremation 3 4 Donation 5 Other (Specif) 21. Signature of Funeral Service Licen	<i>'</i>)	Chesapeal	matory or other place) Ke Cremato	March 2004	9.	Location - City or eltsville	
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Physician /Medica		23a. Part1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	Pneume	_					Interval Between Onset and Death
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DIVISION To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attent completely filled in by the funeral	edical Cert	29a. Certifier 1 \(\textstyle \text{XCertifying Ph} \)	building, etc ysician: To the best liner: On the basis of and manner sta	of my knowledge, deatl	n occurred at the time, vestigation, in my opin	date and place, and ion, death occurred	d due to the cause at the time, date a	(s) and manner as	stated. to the cause(s)
To the within complete	Me	29b. Signature and title of certifier 30. Name and address of person who		th (Item 23a) (Type,	29c. License n	151		Date signed (Month	•
S	ate	Catherine Godfre	M.D.;				Spring, N	1d. 20910	
Regis	ıraf	MAR 1 0 20	U4 /4		7-1-0				

State of Maryland / Department of Health and Mental Hygiene 2004 - 09700For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** RANDALL WHITTINGTON 2004 12:20 PM /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5502 75th Avenue Lanham Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 83 Yrs. 8. Date of Birth (Month, Day, 4 29 9. Birthplace (State or Foreign **Funeral** 1(XM 2□ F Maryland 217-18-2451 Yrs. Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ral', or itema 23a or 28a-f shov Examiner must be notified at 1 X Yes 2 No Director Prince George's Lanham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 20706 U.S.A. 5502 75th Avenue death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filled within 72 hours after inent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural; or ite, any or othar traumatic event. It is Medical Exercites my or othar traumatic event. It is Medical Exercites 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Army Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government 12th Pressman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah Gray Whittington ပ Percv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2219 Columbia Place Landover, Maryland 20785 Carol Leak/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 3-9-2004 Ft. Lincoln Ceme. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service L 7474 Landover Road Landover, Maryland 20785 4 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediete Cause (Final RESPIROTORY FAILURE **Physician** /Medical resulting in death) Due to (or as a consequence of): **Examiner** CHRONIC OBSTRUCTIVE LUNG DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated even in the conditions of the con Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed DEMENTIA that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy 0 in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3℃ Probably 4 ☐Unknown DIABETES 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe certificate 1 Yes 2 X No To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 DOA this 27. Manner of Death 1 Anatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 □ Yes 2 □ No death. 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide hours after within 24 hours at To the Funeral D completely filled it Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who comfleted cause of death (Item 23a) (Type, Print) 1011 N. Capital Street 2nd Fl. N. W. Washington, DC 20002 Bruce Cooper M.D. 31. Date filed (Month, Day, Year) MAR 0 9 2004 32. Registrar's Signature State Registrar

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Catherin	e Kose	e Wiphliams 1- State Registrar	State of Maryla		tificate of l			ne 2004	0970
		1. Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	hysician /Medical	Catherine	Rose	Wi11	iams		Month March 6	Day Year 2004	0011 a ^M
S	Examiner	4a. Fecility Name (If not institution, Fort Washington				Location of Death ashington		4c. County of Death Prince Ge	eorges
	ineral rector	212-72-3388	6. Sex 7. Age (In yn 1 □ M 2 🖾 ¥ 48	s. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye March O,	9. Birthy Cour 1956 Mas	place (State or Foreign ntry) S •
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	a-f show	Usual Residence of Decedent 10a. State 10b. County Maryland Prince		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※No
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deat	arm I	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Vas Decedent of Hi	spanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	
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Maryland od 2 should be file tith and Mental Hy	ema uma	19a. Informant's Name/Relationshi	ip (Type, Print)	19b. Mailin	g Address (Street a	and Number or Rura	al Route Number, Ci	ty or Town, State, Zip	Code)
, Mand 2 and 2 salth a	er tra	Ruth V. William	ns / Mother	203	Creighton	Circle I	Ft. Washin	ngton, MD.	20744
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To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this or completely filled in by the funeral dire Division of

State Registrar

Medical Certification; To

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

29a. Certifier

29b. Signature and title of certifie

28a. Date of Injury (Month, Day Year)

29c. License number OCME

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) March 7 2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)
MAR 0 9 2004

5 Pending investigation

6 Could not be determined



28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryl		e <i>rtificate of L</i>		ental Hygie _{Reg.}	/ U II II II	09702
	Physici /Medi		1. Decedent's Name (First, Middle, Sheldon	Jones	-	Wear			Day Year	3. Time of Death
) 	Examir			Hopkins Hos	pital	Baltimo		y	4c. County of Death	
	Funeral Director		5. Social Security Number 578 84 3472 Usual Residence of Decedent	1 X M 2 □ F	yrs. last birthda Yrs.	Months Days	Hours Min.	8! Date of Birth (Month, Day, Ye SEPT. 03,	9. Birthp Coun 1961 WASI	lecs (State or Foreign htry) HINGTON, DC
	Maryland -f ehow	tor	10a. State 10b. County DC		City, Town or			· · · · · · · · · · · · · · · · · · ·	1	0d. Inside City Limits XXYes 2 □ No
	death with the Maryland ms 23a or 28a-f ehow Lisust be mullied at	al Director	10e. Street and Number 2135 SUITLAND T		VADIIING	10f. Zip Code	020		Citizen of What Coun	
036	after or Ite	by Funeral	11. Marital Status XXNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? d 1 Yes 2700 If Yes, Give Year or Dates:	n U.S. 13	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes XXNo	spanic Origin? (Spec n, Mexican, Puerto F Specify:	ify Yes or No- lican, etc.)	14. Race - Americ Black, White, Specify: BLA	etc.
1215-0036	within 72 hours ene. than "natural", to M. allest Ext.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Giv	edent's Usual Occupa e kind of work done d DO NOT use retired,	luring most of workin)	9	. Kind of Business/Inc	,
Maryland 2	should be filed nd Mental Hygi marked other matic event, the	To Be Co	17. Father's Name (First, Middle, La RICHMOND WEAVER	4YRS.		INVENTOR	Y SPECIAL] 18. Mother's Name MILDRI		<u>DERAL GOVE</u> den Sumame)	RNMENT
	nd 2 silith ar lith ar 27 le		19a. Informant's Name/Relationship MILDRED WEAVER			HOLIDAY	and Number or Rural	Route Number, Cit	y or Town, State, Zip	
Baltimore,	nit. Pages 1 a artment of Hez ortant: If item injury or othe		20a. Method of Disposition XX Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe	□Removal from State CE	cemetery, cri EDAR HII	osition (Name of amatory or other place	Y 10 MAE	R 2004 S	Location - City or To	Œ
n n	Depa Impo		21. Signature of Fuheral Sarvice U	lanshell		308 SULLEY	AND ROAD	SUITLAND	ARYLAND, IN , MD 20746	
	Physician /Medical Examiner		shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a cons	leu	Kemia		respiratory arrest,	1	Approximate Interval Between Onset and Death 4 mon + hs
**	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a cons	sequence of):					
68/60,	tificate be executed g physician and as the burial-transit	edical Ex	resulting in death) Last	Due to (or as a cons	sequence of):					
O. Box 6	death cer e attendin d for use	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre- 1□Live birth 2□F 4□Pregnant at time of 9□Unknown	etal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver Month	ry Day Year
rds, r	w requires that the been signed by the should be detache	by P	Part II. Other significant conditions	contributing to death but not	resulting in the	underlying cause give	n in Part I.		o use contribute to the	e cause of death?
ii Kecords	The law ate has b page 2 sl	Completed						24a. Was an autopsy performed 1 Yes 2 1	prior to com death?	sy findings available apletion of cause of
on or vital	D № A	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of De th Natural 5 Pending investigat	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year,		of 28c, Injury	4 Indising Home		6 □Other (Specify, jury occurred	ı
DIVISION	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 200 Bloom of briggs A	t home, farm, s ecify)			f. Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	the Hospit nin 24 hour the Funera	Medical (one)	Physician: To the best of my le eminer: On the basis of exam and manner stated.	knowledge, dea iination and/or ii	ivestigation, in my opi	inion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To Your	2	29b. Signature and title of certifier	- Jonn		29c. License		- 1	Date signed (Month, D	•
)	(6)		30. Name and address of person who Book flat (Mark Sau Karl	o completed cause of death (I	hns H	plans Ha	pital 60	N Wa	AFE ST BAY	LOUY HOMDERST
	Sta Registr	200	31. Date filed (Month, Day, Year) MAR 1 2 200	. Registrar's Sig	gnature do	e e				

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 23, 2004 **Physician** 19:50 M Ruby M. Woodum /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Ardundel 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Min. 1 □ M 2 F Months Days Hours 95 Yrs. 254-14-0753 Mar 27, Georgia **Director** 1908 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r then "natural", or items 23s or 28s-f show the Medical Examinar must be nutified at 1X Yes 2 □ No Edgewater **Funeral Director Princes Georges** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 414 Washington Road 21403 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Laundry Attendant . Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If item 27 is marked other t jury or other traumetic event, II. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sylvia Reese German Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Gilliard - Granddaughter 566 Weatherwood Court Aiken SC Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Important: I any injury o Fort Lincoln Cemetery 3/3/04 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Meumonia Priysician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ② No Month Day Year 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 **∑** No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification; To Be Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 3 DDA 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide n 24 hours a pelij Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 ho To the Fune completely f and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Skyphin 00058237 Fcb, 23, 2004 Annapolis, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Anne Arundel Medical Ctr Stephen 6 Shaw, MD 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Maryland	Depa	artment of I	lealth and Death		jiene (2004	09701
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Louis Wri					2. Date of Dea Month March	Day 8	Year 2004	3. Time of Death 4:00 P M
	Examin		4a. Facility Name (If not institution, give st 10601 Black Fox				or Location of Dea			ounty of Death rince G	eorge's
	Funeral Director		5. Social Security Number 577-54-8324 Usual Residence of Decedent	M 2□F 7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, Year)	9. Birthp Coun 1 Was	lace (State or Foreign try) h., DC
.0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "neturel", or Items 23e or 28e-f show eny injury or other treumatic event, I'm Medical Examinar must be notified at 90ce.	ed by Funeral Director	10a. State 10b. County Maryland Prince (10e. Street and Number 10601 Black Foz 11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	X Court 2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 N No If Yes, Give Year or Dates:	13.	Mitchell 10f. Zip Code	20721 Hispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	U:	n of What Coun nited S Race - Americ Black, White, pecify: B1	tates an Indian, etc. ack
21215-0036	ed within 72 ygiene. ner then "nel it, the Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 11th	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of w d) Driver			of Business/Inc	•
Maryland	hould be fill d Mental H narked off natic even	To Be	17. Father's Name (First, Middle, Last) Roy Lee Wright 19a. Informant's Name/Relationship (Typ	a Print)	IOh Mair	ng Address (Str.		Lucille Rural Route Number	M. 1	Thompso	
re, Mai	s 1 and 2 st if Health and item 27 Is n other treur		Zilphia E. Wrigh	nt - Wife	1 of Dispo		ck Fox C	t., Mitch	nellv:		D 20721
Baltimore,	permit. Page Department o Importent: If eny injury or once.		1 Surial 2 Cremation 3 Re '4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	Harmo	ony M	emorial Name and Addre	Park 3/1	2/2004 Stewart I	uner		
8760,	The law requires that the death certificate be executed with the action of the attending physician and be detached for use as the burial-transit or the contract of the contra	dical Examiner	23a. Part 1 Enter the disease, or complic shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last d. d.	ations that calised the death. It is cause on each line. Pancreatic Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent)	Cano		ng, such as cardia	ac or respiratory arr	est,		Approximate Interval Between Onset and Death
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al Rec		Completed							ned?	prior to con death?	osy findings available inpletion of cause of 2 No
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director, I	ation; To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Outpatien b. Time of Injury	28c. Inju	ner: 4 🗆 Nursing	Home 5 Peside 28d. Describe ho	ence 6)
Divis	itel or Atte urs after de rel Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				28f. Location (St City or Town	n, State)		
	To the Hospitel within 24 hours a To the Funerel I completely filled	Medicai	29a. Certifier (Check only one) Certifying Physi 2 Medicel Exeminates Medicel Exeminates 29b. Signature and title of cegifier	cian: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or in	occurred et the tivestigation, in my c	ppinion, death occ	urred at the time, d	ate and pla	d manner as states, and due to igned (Month, L	the cause(s)
^	To With		· Mahudh	Hussain	-) /=		D0060050			rch 10,	
K	9		30. Name and address of person who con Mahrukh Hu 31. Date filed (Month, Day, Year)	npleted cause of death (Item 23 188ain, M.D. 12	221 M	Print) [ercantil	e Lane,	Upper Mar	1bor	o, MD 20	0774
	Sta Registr		MAR 1 2 2004	22. Hegistrar's Signature	Loon	W.					

	=		1 - For State Ragistrar		Maryland / Dep Ce	ertificate of L	ealth and N Death	Mental Hygie	ne 200	+ 09705
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Li Gertrude 4a. Facility Name (If not institution, gi	Louise	Wild	4b. City, Town, or	Location of Death	2. Date of Death Month March 6	Day Year 2004 4c. County of Deat	3. Time of Death 7:15 PM
	Funeral Director				Age (In yrs. last birthday 96 Yrs.	Silver If Under 1 Year Months Days	Spring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Dec. 11,	Montgom 9. Birt Co 1907 Was	nery hplace (State or Foreign untry) hington, DC
	th the Maryland or 28a-f show e notified at	Director	10a. State 10b. County Maryland Montgo 10e. Street and Number	mery	10c. City, Town or L			10g.	Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 ☒ No untry?
-0036	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural; or Items 23s or 28s-f show other traumatic event, the Modeal Exeminer man be notified at	by Funeral	1301 Magnolia Ro 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates	No ::	20905 Was Decedent of His If Yes, specify Cuban 1 Yes 2 No	Specify:		USA 14. Race - Ame Black, White Specify: Whi	e, etc.
Maryland 21215-0036	be filed within 72 al Hygiene. f other than "na ivent, the Media	Be Completed	(Specify only highest green state of the sta	ade completed) College (1-40	r 5+) (Givenilife.	e kind of work done du DO NOT use retired) memaker	uring most of work	ing 16b	Own Ho	·
- 17	and 2 should beath and Ments n 27 is marked ier traumatic e	To	Jesse Jackson 19a. Informant's Name/Relationship Stephanie W. Tren		1301	Magnolia	nd Number or Rura	ine O'Lea al Route Number, Cit Silver Spr	ty or Town, State, Z	
Baltimore,	permit. Pages 1 Department of He Importent: # iten any injury or oth		20a. Method of Disposition 1 Service 1 Cremation 3 Communication 3 Communication 5 Communication 3 Communica	<i>(y)</i>	20b. Place of Disp cometery, cre Gate of Cemet	osition (Name of imatory or other place, Heaven ery 2. Name and Address	March 200	Date 2000 n 11,	Location - City or I	Town, State
	Physician		23a. Part1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition		Fr 5 ad the death. Do not en line. atory Failu	ter the mode of dying,	Collins I Sity Blvc , such as cardiac c	Funeral Holl W. Si or respiratory arrest,	me Inc. Iver Spri	ng, MD 20901 Approximate Interval Between Onset and Death
8760,	/Medical Examiner physicien and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of): C Lung Dise s a consequence of): s a consequence of):					Weeks Months
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ital Rec		Be Completed	Dementia 25. Was case referred to medical examiner?			2	26. Place of Death	24a. Was an autopsy performed? 1 Yes 2 N (Check only one)	prior to co	opsy findings available ompletion of cause of
sion	lending Pt eath. or: After th the funeral	ertification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio. 3 Suicide 6 Could not b	28a. Date of Inj (Month, Da		t 28c. Injury a Work? M 1 ☐ Ye	4 Nursing Hon at 2	ne 5 🖾 Residence 8d. Describe how in	6 ☐ Other (Special jury occurred	(57)
Divi	in Pitte	edical Certifi	4 Homicide determined 29a. Certifier 1⊠ Certifying Ph	building, e	ijury - At home, farm, str tc. (Specify) t of my knowledge, death of examination and/or in	n occurred at the time	date and place a	28f. Location (Street : City or Town, Sta	(6) 604	
	To the Hospitel within 24 hours a To the Funerel completely filled		29b. Signature and title of Certifier	and manner s	ated.	29c. License r	number	29d. C	Date signed (Month,	Day, Year)
	Star Registra	e	30. Name and address of person who John G. Lodmell 31. Date filed (Month, Day, Year) MAR 0 9 20	1.D. 32. Regist		Print) y Road, 0	-			

	-	For State Registrar	State of	Marylan		artment of F		ind Mental Hy	giene Reg. No.		09706
		1. Decedent's Name (First, Middle, L	ast)					2. Date of De			3. Time of Death
Physicia /Medica	_	William Edv	vard	Wells,	Sr.			Month	6, 2	/ _{Үөаг}	5:35 PM
Examine		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location o	f Death	4c.	County of Death	
		3118 Gracefield	Road, #	CC 202		Silver	Spri	no	Mo	ontgomer	v
Funeral			Sex 7	Age (In yrs.	last birthday)	If Under 1 Year Months Days		24 Hrs. 8. Date of Bi Min. (Month, D.	rth		place (State or Foreign
Director		577-10-2642	1 🛣 M 2 🗆 F	90	Yrs.	Moritis Days	riours	Oct. 2			Virginia
ъ _		Usual Residence of Decedent		1							
inylar ihow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
Ba-f	Directo	Maryland Montg	omery		Silver	Spring					1 ☐ Yes 2 🔯 No
in the in the interest of the	Sire.	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What Cour	ntry?
23a	<u> </u>	3118 Gracefield	Road, #C	C 202		2090	04			USA	
sme sme	Funeral	11. Marital Status	12. Was Deced Armed Ford	lent Ever in U.	S. 13.	Was Decedent of H	lispanic Orig	in? (Specify Yes or No Puerto Rican, etc.))·	14. Race - Americ Black, White,	
or it		1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	No ⊠ No		1 ☐ Yes 2 ☑ No			1	Specify: Whi	
hours at ural; or	d b	3 Widowed 4 Divorced	Year or Dat	:es:						opecay. WII]	e
T2 7 72 7 72 1 72 1 72 1 72 1 72 1 72 1	Completed	15. Decedent's l (Specify only highest g			16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most	of working	16b. Ki	nd of Business/In	dustry
han dithin	d l	Elementary/Secondary (0-12)	College (1-4	,							
led w	ဒီ		3	3	Tech	nical Di				C News	
	e G	17. Father's Name (First, Middle, Las	it)				18. Mother	's Name (First, Middle	, Maiden	Sumame)	
Men Men arke	0	Charles Lee Wel	ls					lie Columbi			
and and and and and	1	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailie	ng Address (Street	and Number	r or Rural Route Numb	er, City o	r Town, State, Zip	Code)
and and mark		William Edward W	ells, Jr.		6600	Gleamin	Sand	Chase, Co	1umb	ia, MO 2	0144
L H P P P P P P P P P P P P P P P P P P	- 1	20a. Method of Disposition 1 Burial 2 □ Cremation 3	□Romoval from St	C	emetery, crei	sition (Name of natory or other place	(e) M	arch 10,	20c. Lo	cation - City or To	wn, State
Try Bag		`4 □Donation 5 □ Other (Spec		Ce	dar Hi	11 Cemete	ry	2004	Suit	tland, M	arvland
Dealthillor Department of Minoriant: If it any injury or o		21. Signature of Funeral Service Lice	ensee		22	. Name and Addres	ss of Facility				aryrand
		1 (inchew)	Cole	L	50	ancis J. O Univer	COTTI	ns Funeral Blvd. W., S	Home	e Inc. - Spring	MD 20001
ÿ. <u>y</u> 0		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that cau	used the death	n. Do not ent	er the mode of dyin	g, such as c	ardiac or respiratory a	rrest,	Derring	Approximate
Dhysisian		Immediate Cause (Final	9								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	d	ate Ca						S:	ince 1994
Examiner	i	4	Due to (di	r as a consequ	dence or):						
	e	Sequentially list conditions,	b. — Dua to (or	r as a consecu	ienos cify:						
	E .	Cause (Disease or injury									
xecu al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or	r as a consequ	uence of):						
phys s the	rnysician/medical		_ d								
leath certifics attending pl	Me	IF FEMALE:	23c. If yes, outco	ome of oregna	nev						
atten for u	an	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 Fetal	death 3	Ectopic pregnancy			2	!3d. Date of delive Month	ry Day Year
be the	Sic	1 Yes 2 No	4⊟Pregnar 9⊟Unknow	nt at time of de vn	eatn 5∟	Other (specify)			i		
that the de ned by the a detached f	2	Part II. Other significant conditions	contributing to dea	th but not recu	ulting in the co	adoshina ozuna anua	na ia Dant I	220 Did	abaasa	no nantsibuto to th	a cause of death?
w requires that is been signed to should be delta	6	rait II. Other significant conditions	contributing to dea	th but not rest	nting in the u	idenying cause give	m m ranti.		_	se contribute to th	
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law law 2 st	ible.							24a. Was		24b. Were autor	osy findings available inpletion of cause of
The Is	Ö							perfo	med?	death?	2□ No
ding Physician: The h. After this certificate h. funeral director, page	0	25. Was case referred to medical					26. Place	of Death (Check only of			
Physic Physic al direc	0	examiner? 1 ☐ Yes 2 [XNo	Hospital: 1 Inp	patient 2 1	ER/Outpatien	t 3 DOA Othe	er: 4□ Nurs	sing Home 5 🔀 Resid	dence 6	Other (Specify	•)
ding Pt		27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe			
ath. after 5	atio	1 Natural 5 Pending 2 Accident investigate		buy (out)	mony		Yes 2□N	0			
or Attending Physician: Ifter death. Director: After this certification by the funeral director.	Certification	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	d 286. Place of	f Injury - At ho	me, farm, str	eet, factory, office		28f. Location (Street and	Number or Rura	Route Number,
d in Direction	,er	4 E Homeldo	building	, etc. (Specify	7			City or To	vn, State)		
spite nour nere		29a. Certifier 1 ★ Certifying P	hysician: To the b	est of my know	wledge, death	occurred at the tim	ie, date and	place, and due to the	cause(s)	and manner as st	ated.
the Hospitel nin 24 hours a the Funerel I npletely filled	edicai	(Check only 2 Medical Exa	miner: On the bas and manne	is of examinat r stated.	ion and/or inv	restigation, in my op	oinion, death	occurred at the time,	date and	place, and due to	the cause(s)
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to		29b. Signature and title of certifier				29c. License	number		29d. Date	signed (Month, L	Day, Year)
0) () A		-		DE/	270				001
4	+	30. Name and address of person who	completed cause	of death (Item	23a) (Tune	D54	٥/٥		Ma	rch 8, 2	004
		Cheryl A. Aylesw						1.71 *	3.00	20000	
State		31. Date filed (Month, Day, Year)	32. Rec	istrar's Signat	ure _			, wneaton,	MD	20902	
Registra		MAR 0 9 2		perm	19	Sparks					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) Dey Month Year **Physician** March 10, 2004 3:20 am Kam O. Wong /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Name (If not institution, give street end number) Éxaminer Rockville Montgomery Montgomery Hospice- Casey House If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 🛛 F 578-72-8603 91 4, 1912 China Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10e. Stete 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haaith and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Items 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be notified as 1 ☐ Yes 2 🖾 No Directo Maryland Montgomery Olney 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20832 4317 Skymist Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Asian þ 3 X Widowed 4 ☐ Divorced Year or Dates Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Sun He Lee Chun Wong ۵ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4317 Skymist Terrace, Olney, MD 20832 Keith S. Wong/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 12, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Cerebrovascular Acident Examiner Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law raquiras that the death certificata be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completaly filled in by the Inneral director, page 2 should be detached for use as the burial-transit The law raquiras that tha death certificata be exacuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? Be Completed completion of cause of deeth? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 KlOther (Specify) 1 ☐ Yes 2 🖾 No Hospice edicai Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month. Day, Yeer) 29c. License number 29b. Signature and title of certifier rhe MD 42452 March 10, 2004 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) 18111 Prince Philip Drive, #327, Olney, MD 20832 Chitra Rajagopal M.D

Registrar

State

31. Date filed (Month, Day, Year)

MAR 11 2004

Darks

32. Registrer's Signature

			For State Registrar	State of N	Maryland /		artment rtificate				ental Hygi	iene g. No. 2	004	09708
	Dhysisi		1. Decedent's Name (First, Middle, La								2. Date of Death Month March		Year	3. Time of Death
b	Physicia /Medic				1drop						March	2 ^{Day} 20		9:05P M
1	Examin	er	4a. Facility Name (If not institution, gi						Location o				ly of Death	. 1 1
			Anne Arundel N 5. Social Security Number 6.		Genter Age (In yrs. last	birthday)			poli If Under:		8. Date of Birth	1	9. Birtho	
п	Funeral Director			1□M 2 X F	73	Yrs.	Months	Days	Hours	Min.	Dec. 19	, 1930) Mar	place (State or Foreign htry) 'yland
	ъ		Usual Residence of Decedent		-γ									
	anylan show	-	10a. State 10b. County		10c. City, To								1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	8a-f	ecto		George'	s G	lenn	Dal					og. Citizen of	14/5-24 (0	
	with t	5	10e. Street and Number	נ. ח. נ.			10f. Zip		760					niy:
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if item 27 is marked other than "naturel", or items 23a or 23a-f show importants if item 27 is marked other than "naturel", or items 23a or 23a-f show apply injury or other treumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	Armed Force 1 Yes 2 [If Yes, Give Year or Date	s? XNo		f Yes, spec 1 ☐ Yes 2			ĭ, Puerto I	cify Yes or No- Rican, etc.)	Speci	ack, White, ify: Wh	etc. iite
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Maryland	ntal H ed of	Be	Unknown	.,							lvans	aloen Julia		
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Z	and 2 :salth ar		Sam J. Gebbia	/ spous	e	6406	Hi1	1me	ade	Rd.	Glenn	Da1e	e, MD	20769
Je,	item		20a. Method of Disposition	¬¬¬¬¬¬¬	1 00000	of Dispo	sition (Nam	ne of ther place	•)	D	ate 2	0c. Location	- City or To	own, State
Ē	Pages nent of I ant: If it		1 ☐ Burial 2 ☐ Cremation 3 I 1 ☐ Donation 5 ☐ Other (Spec		"etr	оро1	itan	Cr	em.	3-5-	·2004 A	1exan	dria	, VA.
Baltimore,	permit. Departr Importa any inj		21. Signature of Funeral Service Lice	Porcel	P		2. Name and 5 1 2				all Fu ghway			e . 20715
			23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cause on each	sed the death. D	o not ant	er the mode	e of dying	, such as	cardiac	respiratory arre	st,		Approximate Interval Between
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<u>.</u>	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequenc	ce of):								
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Sor	w requir been si should	ete								_	24a. Was ar	24h	Were auto	psy findings available
Il Records,	The ate h page	Completed									autopsy	/	prior to co. death?	mpletion of cause of 2 No
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Ö	s after	Certification;	4 Homicide	bullaing,	, etc. (Specify)						City or Town,	, State)		
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R	(19)		30. Name and address of person wh	completed cause of	of death (Item 23	a) (Type,	Print		A		IN		13/19/	Contex
	Sta	te	31. Date filed (Month, Day, Year)		istrar's Signature		1)1	76	0)	- 10	1 21	16 21 6	1	-641
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Funeral Director		5. Social Security Number 212-67-8003 Usual Residence of Decedent	7. Age (In yrs. la M 2□ F		If Under 1 Months	Year If Under 2 Days Hours	Min. Decemb	ate of Birth Jonth, Day, Yo er 19,	2001	Coun	face (State or I stry) land	Foreign
/land		10a. State 10b. County	10c. City,	Town or Lo	cation					1	0d. Inside City	
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or the	Con	0		Child	l				None			
nd 2 should be filed within 72 hours all tith and Mental Hygiene. 27 is marked other then "natural", or returnatic event, the Modical Exami	To Be	17. Father's Name (First, Middle, Last) Christopher	Wash	ingto	n	18. Mother Deand		at, Middle, Ma.	iden Sumame Thoma			
shou ind M mar umat	-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	ng Address (Street and Number	r or Rural Rou	ite Number, C	ity or Town, S	state, Zip	Code)	
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w O		so. Name and address of person who co	1 1/1/		Print)							
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_		Physici		PRISCILLA	IRENE	1/HIT	E	Month	Day Yeer	1255 M
		/Medio Examir		4a. Facility Name (If not institution, give			y, Town, or Location of Deat		4c. County of Deeth	
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		Funeral Director		5. Social Security Number 6. Se	X 7. Age (In yrs.	/ Yrs. If Unc	der 1 Year If Under 24 Hrs s Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	olace (State or Foreign
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		show		10a. State 10b. County	10c. Ci	ity, Town or Location				10d. Inside City Limits
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		r dea	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Dec	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
	36	urs after death with the Maryla elf, or items 23a or 28a-f shov Exeminer must be molified at	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: 73	ACK
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00	ore	- I = =		20a. Method of Disposition 1 ☑ Buriat 2 ☐ Cremation 3 ☐ F		Place of Disposition (A cemetery, crematory of	lame of rother place) 02-2	21-2004	Oc. Location - City or T	own, State
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	to.	Phys this ral dir	7	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Impatient 2L	☐ ER/Outpatient 3☐ 28b. Time of	4 Nursing P	dome 5 ☐ Resider 28d. Describe hov	nce 6 Other (Speci	fy)
	o	ding P h. After I	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury at Work?		,,	
	Division of Vital Records,	Atten deal octor	fica	3 Suicide 6 Could not be	200. Place of Injury - Act	home, farm, street, fact	tory, office	28f. Location (Stre	et and Number or Rur	al Route Number,
	D	s after	Certification:	4 Homicide	building, etc. (Spec	my)		City or Town,	State)	
		To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		(Check only 2 Medical Exam	vsician: To the best of my kn	nowledge, death occum nation and/or investigati	ed at the time, date and plac- ion, in my opinion, death occi	e, and due to the cau	use(s) and manner as the and place, and due to	stated. o the cause(s)
		thin 2. the I	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number		d. Date signed (Month,	
		T O O		255. Signaturo ario inte di continoi			09191	9	9/100	
				20 Name and 11 11 11 11 11 11 11 11 11 11 11 11 11	Completed source of drawn "	om 22a) /Time Print	401341		4 010	
3	DI	2		30. Name and address of person who o		HEalthw	Com D. Solation	200		
		St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature L	Jan Jansacci	Julien .		
		Ponict		ı FFR 1 8 71	111/1 Mener	- 13 2	works/			

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 26, Day 2004 Year **Physician** Etta Mae Anderson 10:30 рм /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Ivy Hall Geriatric Center Middle River | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 200 231-03-9467 84 Yrs. Director Jan 4.1920 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show item 27 is marked other than "naturel", or items 23a or 28a-f shov other treumatic event, the Medical Exertinar mast be notified at 1 ☐ Yes 2KOXNo Director Maryland | Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 425 South Taylor Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2000 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: ģ 3∕OXWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. Public Sch. 5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Lula Brewer Norman Wilson Black Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is eny injury or other treuonce. 239 Sandhill Road, Baltimore, Maryland 21221 Pamela Peters (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gard March 30,2004 Bel Air, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune of Science Lipers e 22. Name and Address of Eaching Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryalnd 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumania /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of): Physiclan/Medical Examiner The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an certificate ha 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After t Hospitel or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

P.0.

Records,

of Vital

Division

31. Date filed (Month, Day, Year)

WASBEM. 32 Registrar's Signature BASTERN

BLVD - MD-21221

			1 - For State Registrar	State of Marylar		artment of H			iene	2004	N 9	712
	Physic	an	1. Decedent's Name (First, Middle, Last)	izabeth Arnol	l d			2. Date of Deat Month March 21	th Day	Year	3. Time of 7:10	Death D M
*	/Medi Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or Timonium		h	4c. Cour Bal	nty of Death timore	7:10	_Р
	Funeral Director		213-16-6014	7. Age (In yrs. 87	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		^{Year)} 917	9. Birthpl Count Mary		r Foreign
	Maryland of show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		ty, Town or Lo					10	0d. Inside Ci	
	th with the 23a or 28e	al Director	10e. Street and Number 2300 Dulaney Valle	y Road		10f. Zip Code 210	93	1	0g. Citizen d	of What Count	ry?	
920	urs after dea al', or Items Xentiret m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1	-	Was Decedent of His f Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	В	lace - America lack, White, e cify: whi	etc.	
Maryland 21215-0036	vithin 72 hound. ne. han "natura	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of wor	king		Business/Ind		spita
and 2	t be filed value of the Hygie of other to event, III	Be	17. Father's Name (First, Middle, Last) Joseph Marks		кесер	tionist		ne (First, Middle, M	Maiden Sum	ame)	-	
Maryl	12 should h and Me 7 is mark raumatic	₽	19a. Informant's Name/Relationship (Ty	•	1	g Address (Street a	nd Number or Ru		City or Tow	m, State, Zip	Code)	
Baltimore, I	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, Ita Medical Exemiter must be notified at ORGE.		Laura Parulis-niec 20a. Method of Disposition 1 XBurial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State Gar	Place of Dispo- cemetery, cren dens o	ine Valle sition (Name of natory or other place f Faith . Name and Address 415 Belai	3/25 s of Facility Mi	5/2004 11er-Dip	20c. Location Baltin pel Fu	n-City or Tov nore, N ineral	Maryla Home	nd
8760,	cate be executed / Medician and physician and physician and physician and it is the burial-transit	dical Examiner	23a. Part Lenter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions. In the cause, Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	OBS7 juence of): juence of):	RUCTIVE		t .			Approximate Interval Bette Onset and D	ween
.O. Box 6	ath certifi ttending or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of continuous 1 Unknown	Il death 3 🗆	Ectopic pregnancy Other (specify)				Date of deliver		'ear
ords, P.	w requires that the de been signed by the a should be detached f		Part II. Other significant conditions con			derlying cause giver	n in Part I.	23e. Did tob		ontribute to the	e cause of de	
al Reco		Completed						24a. Was ar autopsy perform 1 ☐ Yes 2	ned2	prior to com death? 1 Yes 2	pletion of ca	ivailable iuse of
of Vit	Attending Physician: The r death. ector: After this certificate ha ector: After this certificate hay the funeral director, page	n: To Be	27. Manper of Death	ospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Input (Month, Day Year)	28b. Time of	0.5	4 V Nursing H	th (Check only one ome 5 Resider 28d. Describe hore	nce 6 🗆 O			
Division of Vital Records,	- 9	Certification;	1 Matural 5 Pending 2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	Injury ome, farm, stre y)	M 1 🗆 Y	es 2□No	28f. Location (Str City or Town	eet and Nun State)	nber or Rural	Route Numt	Der,
	To the Hospital or within 24 hours aff To the Funeral Di completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physical Check only one)	ician: To the best of my knower: On the basis of examination and manner stated.	owledge, death ition and/or inv	occurred at the time estigation, in my opi	a, date and place nion, death occu	, and due to the ca rred at the time, da	use(s) and nate and place	manner as sta	ted. the cause(s)	
)	To the within 2 To the complet	×	29b. Signature and title of certifier Carry Carry 30. Name and address of lerson who co	mpleted cause of death (Iter	n 23a) (Tvpe. I		number 0 16619		_	led (Month, D	-	
	Sta Registr	ar	CORAZON VERGARA-S 31. Date filed (Month, Day, Year) MAR 3 0 2004		2300 D	OULANEY VA	LLEY ROA	AD TIMON	'IUM', I	MD 210	93	
DH	MH 17 Rev 1/2	001	· · · · · · · · · · · · · · · · · · ·	<i>*</i>	,							

ORIGINAL

MARCH 21, 2004

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March ^{Day} 28 2004 **Physician** 5:45 PM Bargar Virginia Μ. · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Arnold Future Care Chesapeake 8. Date of Birth (Month, Day, Year) 0Ct. 04 1921 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 ☐ M 2 🛣 F WV 82 Yrs. 235-30-0143 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💢 No Pasadena Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 1396 Rainbow Drive 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 3altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: δ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Household 12 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lambert Elsie Lambert Lesley Troy ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1396 Rainbow Drive, Pasadena, MD 21122 (daughter) Gail Schimpf 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mar. 2004 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Stallings FuneralHome, P.A. 21. Signature of Funeral Service License 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure). List only one cause on each line. Approximate Interval Between Onset and Death **Physician** (EUMONI Immediate Cause (Final disease or condition resulting in death) /Medical Examiner DISORDER Physician/Medical Examiner physician and s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): es. attending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DEMENTIA SENILE ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 Tes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: filled in by the funeral director, å 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4160 MARCH 29, 2004 HIGHWAY, BAGIMORE h((Item 23a) (Type Print) RT

State Registrar 31. Date filed (Month, Day, Year)

MAR 3 0 2004



1 - For State Registrar 1. Decedent's Name (First, Middle, Last) Physician (Medical Continuous Properties of Death Properties Prop	2. Date of Death	g. No. 3. Time of Death	
Physician IDA/V	Month	David Maria	
Medical 1011 y 1300 F C-2	03	27 2004 10 30PM	
4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De FUTURE CARE NURSING CENTER BALTIMORE	eath	4c. County of Death N/A	
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 If	Irs. 8. Date of Birth in. (Month Day,	9. Birthplace (State or Foreign	
Director 216 78 4980 XM 2 F 39 Yrs.	NOV. 26,	1964 MARYLAND	
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits	
BÁLTIMORE N/A		X Yes 2 No	
106. Street and Number 106. Zip Code 21217		g. Citizen of What Country? J.S. OF A.	
1701 EUTAW PLACE APT. 214 21217		14. Race - American Indian,	
Armed Forces? Armed Forces? If Yes, specify Cuban, Mexican, Pt.	erto Rican, etc.)	Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 16b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Education (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working	6b. Kind of Business/Industry	
Elementary/Secondary (0-12) College (1-4or 5+) 9TH GRADE UNKNOWN UNEMPLOYED			
N position of the state of the	Name (First, Middle, Ma		
The part of the pa		BERT (DECEASED)	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of PRANCES ROBINSON (SISTER) 7101 RUTHERFORD G	REEN CIR.	City or Town, State, Zip Code) BALTO., MD.21244	
20a. Method of Disposition 20b. Place of Disposition (Name of METRO) 20c. Place of Disposition (Name of METRO) 1 Durial 2 Cremation 3 Removal from State 1 Durial 2 Cremation 3 Removal from State	Date 3/30/04 ²⁰	CATONSVILLE, MD.	
14 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee LEWIS T. GWYNN 22. Name and Address of Facility LEWIS T. GWYNN	THE PARTY OF THE P	HOME 21215_6393	
TA DIRA - A MINISTER 1517 DARK HELG	HTS AVENU	HOME 21215-6393 UE BALTO.,MD.	
23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as can shock, or heart failure. List only one cause on each line.	diac or respiratory arres	st, - Approximate Interval Between Onset and Death	
	ncel		
Examiner			
Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events b. Due to (or as a consequence of a cause (Disease or injury that initiated events)			
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Co. Due to (or as a consequence of):			
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The law required to medical symmetry of the la	24a. Was an autopsy perform	prior to completion of cause of	
T of the same retented to medical	1 ☐ Yes 2	No 1 □ Yes 2 □ No	
25. Was case referred to medical examiner? 1			
D	28d. Describe hov	w injury occurred	
1 Tyes 2 No 1 Tyes 2 No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Str	eet and Number or Rural Route Number,	
27. Manner of Death 1 Deatural 2 Accident 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. I me of Injury M 28b. I me of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No	City or Town,	, State)	
29a. Certifier 1 Dertifying Physicien: To the best of my knowledge, death occurred at the time, date and p			
one) and manner stated. 29c. License number		Od. Date signed (Month, Day, Year)	
Cum VII	May 2 MD D3912/ 3/28/2004		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A AHMED MD & Z I N Eulaw St	Ballin	ore MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		(

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 2004 2:00 a M **Physician** Albertha Roselee Beyer /Medical 4c. County of Death 4b. City, Town, or Location of Deeth 4e. Fecility Name (If not institution, give street and number) Examiner Baltimore Reisterstown 15237 Dover Rd. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 24. 1929 9. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 K F 212-26-4473 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or itama 23a or 28a-f ehov the Medical Exemples must be notified at 1 ☐ Yes 2 No Maryland Baltimore Reisterstown Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 U.S.A. 15237 Dover Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) other than Elementary/Secondary (0-12) Housewife Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth ery injury or other traumatic event 2008. William Alexander Stockum Marion Elizabeth Cassette 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15237 Dover Rd. Reisterstown Md. 21136 Edward Beyer - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from State LakeView Mem. Park March 31,2004 Sykesville, Md. * 4 □ Donation 5 □ Other (Specify) 21. Signature of up rel Service License 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 Approximate Interval Between Onset and Death 2 MONTHS 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CANCER METASTATIC COLON **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) ed by the attending physician detached for use as the buria Box 68760. by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HEART FAILURG CONGESTIVE 4 Unknown 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No has 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After Hospital or Attending 1 Satural
2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No the 6 Could not be 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insert Section 1] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Cou s of prson who completed cause of death (Item 23a) (Type, Print) 1406 S. CRAIN HIGHWAY D. 21600 Suite 106 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 0 2004 Registrar

		State of Maryland / Department of Health and Mental Hygiene 2004 09716 Certificate of Death Reg. No.
Physic /Med	ical	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 11: 05AM
Exami Funera Directo	1	4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or items 23e or 28e-1 show any injury or other treumetic event, the Medical Examination until the Indifferant once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1
ficate be executed Wedical Examiner is the burial-transit edical Examiner		Approximate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
n of Vital Records, P.O. Box on Physicien: The law requires that the death certifier this certificate has been signed by the attending meral director, page 2 should be detached for use a on: To Be Completed by Physician/M.	0	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year 4 Pregnant at time of death 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Verification 1
	Completed by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive went fculure Drawetes melitus 23e. Did tobacco use contribute to the cause of death? 1 yes 2 No 3 Probably 4 Storknown 24a. Was an autopsy performed? 1 yes 2 No 1 yes autopsy findings available prior to completion of cause of death? 1 yes 2 No 1 yes 2 No
	m	25. Was case referred to medical examiner? 1 Yes 2 Mo 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury 28b. Time of Injury Work? M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined 1 Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number, determined 28f. Location (Street and Number or Rural Route Number)
Divisio To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the ft		4 Homicide building, etc. (Specify) 29a. Certifier (Check only City or Town, State) 29a. Certifier (Check only 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
•	Medi	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 27, 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25bert M. COOPE MI) 6503 PARIC Herfuls ARE BATTMORE MM 21215
S Regis	tate	Robert M. COOPER MY 6503 PARIC Heights Are BAUTMONE MY 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

BerKowitz, Edith

ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey **Physician** March 27, 2004 James S. Black 12:55 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Mariner Health of Catonsville Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAY 3, 193 9. Birthplece (State or Foreign Country) South Carolina 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1**∑** M 2□ F Yrs. Director 249-48-7039 69 1934 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Neme 23a or 28a-f show any injury or other traumatic event, in Medical Examinat must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √2 Yes 2 □ No Be Completed by Funeral Director N/A Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4212 Ivanhoe Avenue 21212 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Black 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Automobile Reconditioner Car Dealership 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Sylvester Black Annie Scot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janie L. Black/Wife 4212 Ivanhoe Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 3-29-04 Baltimore, MD 21. Signature of Fun ral Service Lights

Edward A. Gregorchik 22. Name and Address of Facility
Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) Cerebrovascular accident /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine signed by the attending physiclan and be datached for usa as the bunal-transit The law requiras that tha death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown s has been signed age 2 should be d ģ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate ha funeral director, page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 28c. Injury at Work? 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Neturel To the Hospital or Attendin within 24 hours after daath.
To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number D005728 person who completed cause of death (Item 23e) (Type, Print) 4920 Campbell Blud, Balhowe us 21236 OSEI-BOATENE, 31. Date filed (Mo. 32. Registrer's Signeture State 386450 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Bitnie Yeer Physician grace 0055AM March 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Social Security Number Birthplece (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F 75 Director 156-20-0462 July,22,1928New Jersey Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic sysnt, the Martical Examinar must be notified at MD Howard Columbia 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 271s marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes A No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: white 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Exec. Secretary MEdical Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dunbar P. Birnie Ruth Perrine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dunbar P. Birnie/Brother 5033 Eliots Oak Road, Columbia, Md. 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages
Department of
Important: If It
any injury or o Balto/Wash.Crem. 1 ☐ Burial ② Cremation 3 ☐ Removal from State 04/01/04 Laurel, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Liceny 7.83°C 5555 Twin Knolls Rd.Columbia, Md. 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 7 days Physician Winary Tract disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner onic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transi attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Yes 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed Pulmonar 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Obstructive 24a. Was an autopsy 2 X No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: completely filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital within 24 hours a To the Funeral (1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) m.D march 28, 2004 5653 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Columbia, mD21044 10780 Road HICKORY Harry 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3 0 2004

			For State Registrar	State of M	larylan		artmen <i>rtificat</i>				lental Hy	giene Reg. No		04	09	719
	A. (19)		Decedent's Name (First, Middle, Last	st)							2. Date of Do	eath Da	ay Ye	ar	3. Time of [)eath
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		2				last birthday		r 1 Year	If Under		8. Date of Bi	rth	9	Birthpla	ace (State or	Foreign
	Funeral Director		216-16-1562	Sex X M 2 □ F 7. A	80	Yrs.	Months	Days	Hours	Min.	Nov. 1	, 19	23 M	lary	land	
	p ,		Usual Residence of Decedent 10a, State 10b, County		10c Cit	y, Town or L	ocation							10	d. Inside City	/ Limits
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	death with the Maryland ms 23a or 28a-f show	Director	Maryland Baltimo	re		Luther		Code				10g. C	. Citizen of What Country?			
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)	items items	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	.S. 13.	Was Dece If Yes, spe	dent of Hi city Cuba	ispanic Or n, Mexica	rigin? (Spann, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, N			
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2 2	should ind Men marke	은	19a. Informant's Name/Relationship (19b. Mail	ing Addres	s (Street			al Route Numi					
SE	and 2 Balth a n 27 ls		Josephine Bond	Wife		A CAMPAGE CONTRACTOR	Pick		Road		hervil					
A s	ages 1 ant of He t: if Item y or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from Stat	e Du°	Place of Disp Pariety	valor (Na	me of other place	ce)		Date		Location - Cit			
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Bal	permi Depar Impo any ir		21. Sign und Chonelai betrice Lice	1300	-		1050			i i	ck Townson,			212		nc.
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that cause one cause on each	ed the deat	th. Do not er	nter the mo	de of dyin	ng, such as						Approximate Interval Betw	reen
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100	/Medical Examiner		resulting in death)	Due to (or a	as a conseq	uence of):	1-00	1	C	1.						
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ó	cate be executed physician and s the burial-transit		resulting in death) Last	Due to (or a	s a consec	quence of):						0				
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of V	Physici this cer al direc	ToB	examiner? 1 🗆 Yes 2 🔲 No	Hospital: 1 Inpa		ER/Outpatie				lursing Ho	me 5□Res			Specify)	
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	the H	Medi	one) 29b. Signature and title of certifier	and manner	stated.		29	e. Licens	se number			29d. D	ate signed (A	Aonth, L	Day, Year)	
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	Sta Regist		31. Date filed (Month, Day, Year)	004 32 Regi	strar's Sign	atale A	294	p.								!

Stella Maris Hospice Stella Maris Hospice Timonium S. Social Security Number S. S	Baltimore 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes XX No of What Country? USA ace - American Indian, lack, White, etc. city: White Business/Industry S. Government ame) m, State, Zip Code)
Stella Maris Hospice Funeral Director Funeral	Baltimore 9. Birthplace (State or Foreign Country) Maryland 10d. Inside City Limits 1 Yes XX No of What Country? USA ace - American Indian, lack, White, etc. city: White Business/Industry S. Government ame) m, State, Zip Code)
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Description Description	TOOU
Physician /Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	n - City or Town, State
Physician /Medical Examiner The property of t	21204
Cause. Enter Underlying Cause of contends and Cause (or injury) that initiated events resulting in death) Last Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Approximate Interval Between Onset and Death
SO TO SET	
O of the first of the past 12 months? 1 FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2 Unkno	Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ontribute to the cause of death? 3 Probably 4 Unknown
autopsy performed? 1 Yes 2	b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
performed?	other (Specify) HOSPICE
O state of the sta	urred
A continuity - At home, farm, street, factory, office 281. Cocation (Street and Num City or Town, State) 282. Cocation (Street and Num City or Town, State) 283. Cocation (Street and Num City or Town, State) 284. Cocation (Street and Num City or Town, State) 285. Cocation (Street and Num City or Town, State) 286. Place of Injury - At home, farm, street, factory, office 287. Cocation (Street and Num City or Town, State) 288. Cocation (Street and Num City or Town, State) 289. Cocation (Street and Num City or Town, State) 280. Cocation (Street and Num City or Town, State) 281. Cocation (Street and Num City or Town, State) 281. Cocation (Street and Num City or Town, State) 281. Cocation (Street and Num City or Town, State)	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and no course of the course of the cause of the ca	ned (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 State 31. Date filed (Month, Ogy, Year) 32. Registrar's Signature	29/04

MARCH 29, 2004 1:24 a.m.

JAMES BROWN

			State of Maryla	nd / Department of Health and M Certificate of Death	ental Hygien	900	09721
	, a		Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic		MURTLE JETTINI	A BROOKS	March 2	1,2004	1130 A M
	Examin		4a. Facility Name (If not institution, give street and number) Many land General Hospita	4b. City, Town, or Location of Death Baltimore	4	c. County of Deeth	A
	Funeral	,3c	5 9 100 100 100 100	S. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthp	lace (State or Foreign
4	Director		Usual Residence of Decedent		DEC:31,1		RYLAND
	ryland	L	10a. State 10b. County 10c. 0	City, Town or Location	- 0 -11	1	0d. Inside City Limits 1 Yes 2 No
	with the Maryland s or 28a-f show	Funeral Director	MARYLAND N/A 10e. Street and Number	BALTIMORE 10f. Zip Code		Citizen of What Cour	, ,
	ath with	i Dir	(511 N. STREEPERS		25	USA	
	₽ E 5	unera	11. Marital Status 12. Was Decedent Ever in Armed Forces?		ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
38	hours after turel', or its	by Ft	1/S\Never Married 2 ☐ Marned 1 ☐ Yes 2 ØNo If Yes, Give Year or Dates:	1 ☐ Yes 2Å No Specify:		Specify: BL	ACK
5-0-5	72 ho netur	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	sing 16b.	Kind of Business/In	dustry
7	filed within 72 Hygiene. Ither than "nef int, It e Medic	dmo	Elementary/Secondary (0-12) College (1-4or 5+)	TANITOR		APTAU	VGLASS
	be filed ta! Hygi d other	BeC	17. Father's Name (First, Middle, Last)	7	e (First, Middle, Maid		000115
Mand	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If item 27 is marked other than or other treumatic event, It a M	10	DAV/ \D 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rur	TAL Poute Number, City		ROOKS
Mar			DEBORAH FRANKSDAUGH	1	e ST. BA	LTO, MI	21205
rock imore,	es 1 and of Health if item 27 or other tr		20a. Method of Disposition 1, Surial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)		Location - City or To	own, Stete
3 rook	permit. Pages 1 and Department of Health mportent: If item 27 any injury or other to		*4 □Donation 5 □ Other (Specify)	17. ZION CEMETERY 3-3	30-04 4	THIS DOLLY	PAN HOME.
Bal	permi Depar Impor any ir		21. Signature of Euneral Service Licensee	NJ PISER HELL TO	NAVE.	BAITO,	MD 21217
			23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	of Left Foot			Oliset and Death
	/Medical Examiner		Due to (or as a cons	al Vascular Dis	sease		
	=	ner	cause. Enter Underlying	equence of):			
V	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (gr as a cons	equence of):			
760,	te be ex ysician ne buria	calE					
68	ifica g ph as th		IF FEMALE:				
Bo	eath ce attend for use	by Physician/Med	23b. Was decedent pregnant in the past 12 mopths?	etal death 3 Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
0	it the d by the tached	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
IS, F	Physicien: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to t	_/
Sorc	w requi	Completed			24a. Was an	24b. Were auto	opsy findings available impletion of cause of
Re	The lav	фшо			autopsy performed	? death?	
/ital	icien: Thi certificate ector, pag	Be	25. Was case referred to medical examiner?	Othor	th Check on one		
o Jo	tending Physicien: The leath. Tor: After this certificate he time funeral director, page	၉	1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of Injury (Month, Day Year	ELER/Outpatient 3 DOA 4 Nursing H	ome 5 Residence 28d. Describe how in		(y)
<u>o</u>	Attending ir death. ector: After by the fune	ation	2 Accident investigation	Injury Work? M 1 Yes 2 No			
Division of Vital Records, P.O. Box	or Atte fter de: Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	it home, farm, street, factory, office ecify)	28f. Location (Street City or Town, St		al Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft		29a. Certifier 1 Certifying Physician: To the best of my	knowledge, death occurred at the time, date and place ination and/or investigation, in my opinion, death occu	, and due to the cause	e(s) and manner as	stated.
	the Ho in 24 I the Fu npletely	Medical	one) and manner stated.	29c. License number		Date signed (Month,	
	Mith To COL		29b. Signature and title of certifier	89508	2	24.0	4
	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1000	1100-1	1
			31. Date filed (Month, Day, Year) 32. Registrar's Si	0	beneral	HOSPITA	€ [
	Si Regis	ate Irar	MAR 3 0 2004 Benevia	4			
	DHMH 17 Rev 1/	2001		ORIGINAL			
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ADH DAVID BARKLEY 4-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2145	5		1 - State Unpend Item#23a,27,28a f,PenMCG830,4/704	tment of Health and	Mental Hygier	ne 2001	00700
			1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg. I	No. 2004	3. Time of Death
	Physici		DAVID	PRKLEV	Month [28. 2004	0625 A M
	/Medic Examin			4b. City, Town, or Location of Dea		4c. County of Deeth	1002.1 A
				BALTIMORE CITY		NI	A
3	Funeral			If Under 1 Year If Under 24 Hrs Months Days Hours Min			place (State or Foreign ntry)
	Director		Usual Residence of Decedent		DEC:01,1	100 111	ARYLAND
	how the		10a. State 10b. County 10c. City, Town or Local	ition	0		10d. Inside City Limits
	Ba-f s	octo	MARYLAND N/A	BALTIHO		-i/	1/A Yes 2 No
	with ti	D	10e. Strylet and Number	10f. Zip Code	15	Chizen of What Cou	ntry r
	death with the Maryland me 23e or 28e-f show Fraust be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	as Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - Amen	
9	or ite		1 Never Married 2 Marned 1 ☐ Yes 2 No	res, specify Cuban, Mexican, Puè ⊇Yes 2 /∑N o <i>Specify:</i>	no Hican, etc.)	Black, White,	etc.
5-0036	hours after turel', or ite	Completed by	3 Wildowed 4 Divorced Year or Dates:		105	1.07	ACK
215-	in 72 n • net	plete	(Specify only highest grade completed) (Give kii	nt's Usual Occupation nd of work done during most of wo O NOT use retired)	orking 160.	Kind of Business/Ir	laustry
212	d within grene. or than	mo;	Elementary/Secondary (0-12) College (1-4or 5+) 12 HGRADE CON	STRUCTION W	ORKER ST	TOP CON	STRUCTION
	be filled tai Hygi d other event, I	Be	17. Father's Name (First, Middle, Last)	18. Mother's Na	me (First, Middle, Maid	en Sumame)	
Maryland	Ment Ment Marke Marke Marke	2	PRESTON I HEODORE BAK	ELLEY GAIL	- HELE	N 1-0	WLER
Ma	is 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "neturel", or Items 23s or 28s-f show other traumatic event, the Medical Exacilizar must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or R	AVE BA	y or lown, State, Zij	MD 21215
ē,	s 1 and f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition	ion (Name of tory or other place)	7 1 1 tan	Location - City or To	
SE .	Pages nent of int: If i		1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)		31-04 W	DONLAG	UN. MA.
Baltimore ,	permit. Page Department o Important: If any injury or once.			Name and Address of Facility	BROWN-JI	P. FUNER	PAL HOME
177	80E 3 0		which N. Wellamo &	2140 N. FULI	ON AVE. K	BALTO, M	10, 2/2/7 Approximate
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) Narcotic, Cocaine and E	thanol Intoxication			
Ē	Examiner						
	De sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transit	Examiner	resulting in death) Last C. Due to (or as a consequence of):				
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Вох	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetel death 3 □ E	ctopic pregnancy		23d. Date of delive	ery Day Year
	0 0	by Physician/Med	1	Other (specify)			ŕ
, P.O	requires that the een signed by th nould be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part 1.	23e. Did tobacc	o use contribute to t	he cause of death?
Records,	w requires that been signed to should be dete	ed b			1 🗆 Yes	2 □ No 3 □ Prot	pably 4 Unknown
ဝ၁ခ	aw 1s b	Completed			24a. Was an autopsy	prior to co	ppsy findings available impletion of cause of
R	ate pag	Con			performed? Yes 2□		2 No
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner? 15€ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ ER/Outpatient	04	ath Check on yone	0.77 William 100 miles	
of		n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	Home 5 Residence 28d. Describe how in		AT SCENE
ion	Attending F r death. ector: After by the funer	atio	2 Accident investigation ound3/28/04 found6:15		unknown		
Division	br Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street City or Town, Sta	ate)	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Ce	tound at home 29a. Certifier 1□ Cartifying Physician: To the best of my knowledge, death of	occurred at the time, date and place	5408 Lynview		
	24 hc 24 hc Fun etely	Medical	(Check only one) Madical Examinar: On the basis of examination and/or investigation on the basis of examination and/or investigation on the basis of examination and/or investigation on the basis of examination and/or investigation of the basis of examination of the basis of examination of the basis of examination of the basis of the				
	Vithin To th comp	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
	1		Hatillion-Pollal my	OCME	M	ARCH 28,	2004
	4		39 Name and address of person who completed cause of death (Item 23a) (Type, Pr	nn Street, Balt	imoro Marri	1and 2120	1
	Sta	ato	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ini Street, Dall.	more, Mary	TGT 10 5150	1
	Regist		MAR 3 0 2004 Sente				
DH	IMH 17 Rev 1/2	2001	A Apo	EKS/			
			ORIĞINA	L			

State of Maryland / Department of Health and Mental Hygiene 200 l For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 2004 14:06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Date of Birth (Month Day) 9. Birthplace (State or Foreign Dougla) LAND 6. Sex 7. Age (In yrs. last birthday) **Funeral** 212.11.46eD Days 10 M 2□F Months Hours Director Usual Residence of Decedent 10d. Inside/City Limits State 10b. County 10c. City, Town or Location r than "natural", or Itema 23a or 28e-f ahow the Medical Examiner must be notified at MD PALTIMORE 1 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Croan, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Black, White, etc. orces7 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NONE other Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be UN KNOWN 19b. Mailing Address/IStreet and Nur KOB 2310 MoTHER 20b. Place of Disposition (Name of cometery, crematory, or other place) Baltimore, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State EMETERY 4 ☐ Donation 5 ☐ Other (Specify) permit. 23 Name and Address of acility
4905 YORK 21. Signature of Funeral Service Licensee once. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. dying, such as cardiac or Immediate Cause (Final disease or condition Physician unshot resulting in death) /Medical e to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buris Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 1 Tyes 3 Probably 4 Unknown should I 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 \(\sum \) No autopsy performed certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1X Yes 2 ☐ No 2 XER/Outpatient 3 DOA 1 Inpatient 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury CPM 1 Natural 5 Pending investigation Shot Subject death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide idence rear To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E. March 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 SONICA State

DHMH 17 Rev 1/2001

Registrar

	_	For State Registrar	State of Marylan	d / Depa	ırtmer	nt of Healt te of Dea	h and Me	ntal Hygie	ne 2nn		
Physicia /Medic Examina Funeral Director	al	4a. Fecility Name (If not institution, give so Northwest Hosp 5. Social Security Number 6. Sex		Belliast birthday).	4b. City	Town, or Local	ion of Death	Date of Birth	4c. County of Dea		
0	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore 10e. Street and Number	₩oo	y, Town or Lor dlawn		p Code	207		Citizen of What C		
urs atter death with	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		B. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 No Specify:				United States 14. Race - American Indi Black, White, etc. Specify: White		
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penint. Tages failed as blood of the maintenance of the second of the se		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	Baltimore -	. 22	gton	Cremat	acility Loris	ch 28, 2	Funeral	rTown, State el, Marylan Directors 1133-4784	
hysician /Medical xaminer		23a. Pant. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	th. To not ent	er the mo					Approximate Interval Between Onset and Death	
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After this funeral dis	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	lospital: 1 Impatient 2 E 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		OOA Other: 4 28c. Injury at Work? 1 Yes	28	5 ☐ Residence d. Describe how	ee 6 Other (Sp injury occurred	ecify)	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	al Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec sician: To the best of my kn	ify)owledge, deat	th occurre	ed at the time, da	ite and place, an	City or Town, S	State) se(s) and manner a	Rural Route Number, as stated.	
within 24 h To the Fur	Medical	29b. Signature and title of certifier 30. Name and ad 185 of person who co	ner: On the basis of examin and manner stated.		2	9c. License nun	nber	29d	. Date signed (Mor	nth, Day, Year)	
St	ate	31. Date filed (Month, Day, Year) MAR 3 () 2004	32. Registrar's Sign	L Old	Con	et Ro	i Ran	nder (ISD)	a, who	21121	

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of	Maryland			of Health a	and Mental Hy	/giene Reg. No. 2004	09725		
	Physici /Medic	al	Decedent's Name (First, Middle, I Joan Elizabet	h Bennet					2. Date of De Month March	Day Year 27, 2004	3. Time of Death		
	Examin	er	4a. Facility Name (If not institution, g 609 Mulberry La	ne			Edgew			4c. County of Death Harford			
	Funeral Director		5. Social Security Number 6. 222–18–3073 Usual Residence of Decedent	Sex 7.	Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Your Months Da		Min. 8. Date of Bi (Month, Di July 6		place (State or Foreign ntry) Ware		
	r 28a-f show	o	10a. State 10b. County	مم		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√2 No		
	the 28a	Directo	Maryland Harfo 10e. Street and Number		EC	lgewoo	10f. Zip Coo	de		10g. Citizen of What Cou	g. Citizen of What Country?		
	eath with is 23a or	eral	609 Mulberry La	12. Was Decede	not Ever in III	2 12	210		nin? (Specify Vec or N	USA 0- 14. Race - Ameri	oan Indian		
5-0036	hours aftar di tural', or Item al Eral· Lati	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Force	∍s? ∑ No		f Yes, specify (gin? (Specify Yes or No , Puerto Rican, etc.)	Specify			
7	n 72 r "na'	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		or 5+)	(Give	DO NOT use re	one during most	t of working	16b. Kind of Business/In	dustry		
d 21			12 17. Father's Name (First, Middle, La	st)		Wai	tress	18. Mothe	r's Name (First, Middle	Restaurant			
Maryland	Mantal Mantal arkad c	To Be		seph	Ba	rber	o Address /St	Mar	garet He	len Davenp			
Ma	d 2 s th ar 7 is trau		Debbie Pillsbur		or				Edgewood.	per, City or Town, State, Zij Mio 21 040	(Code)		
Baltimore,	agas 1 and and of Haall of Haall of Haall of You other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	Removal from St	20b. Pl	ace of Dispo metery, crer	sition (Name o natory or other	place)	-31-04	20c. Location - City or To			
1 Donation 5 Other (Specify) Longwood Cemetery 3-32 21. Signature of Funeral Service Licensee 22. Signature of Funeral Service Licensee 23. Signature of Funeral Service Licensee 13. Signature of Funeral Service Licensee 13. Signature of Funeral Service Licensee 13. Signature of Funeral Service Licensee								1 Home, P.	Α.				
	Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition		Approximate Interval Between Onset and Death								
ı	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or	as a consequ	ence of):	dile	led co	irelounge	ruthy			
,092	ita ba axacutad iysician and na burial-transit												
687	iticata g physi as tha l			d									
.O. Box	The law requires that the death certiticate be execution the has been signed by the attending physicien and organ 2 should be detached for use as the burfal-tran	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal t at time of de	death 3	Ectopic pregna Other (specif)			23d. Date of delive Month	ery Day Year		
4	n raquiras that baan signed b should be data		Part II. Other significant conditions	contributing to deal	h but not resu	Iting in the u	ndentying cause	given in Part I.	I alaki a	tobacco use contribute lo t. ∕res 2 □ No 3 □ Prot			
Division of Vital Records,		Completed	Chromic o	OSTYLL	we	pieln	where	y dis	24a. Was auto perfo 1 🗆 Yes	s an 24b. Were auto prior to coormed? death? 1 \(\) Yes	psy findings available impletion of cause of 2 \(\text{No} \)		
Vita	sician: Th certificata iractor, pag	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	-111 005	-5/0		04	of Death (Check only		Daughtorla		
J Of	g Physian this neral di	n: To	27 Mannar of Doath	28a. Date of (Month,		ER/Outpatier 28b. Time of Injury		Injury at Work?		idence 6 X Other (Specif how injury occurred	Residence		
ivisior	or Attanding Physician: iftar daath. Director: Attar this certifici in by tha luneral diractor, i	Certification:	Natural 5 Pending investigat 3 Suicide 6 Could not determine	ion				1 □ Yes 2 □!		Street and Number or Rura wn, State)	ul Route Number,		
D	pital ours a aral l	ledical Cer	(Check only 2 Medical Ex	aminer: On the basi	s of examinati	vledge, deatl	n occurred at th	ne time, date and	d place, and due to the	cause(s) and manner as s	tated.		
	To tha Hos within 24 h To tha Fun complataly	Med	one) 29b. Signature and title of certifier	and manne	stated.	-	29c. Lic	cense number		29d. Date signed (Month,	Day, Year)		
	4		1 Have San	1 (Cruc		20.15	D:	37364		March 29,			
	\		19 Walnut	- Cane	Abe	rde	2u, (4	ary	and				
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 0 20	04 Reg	istrar's Signat	ure	W.	3					

State of Maryland / Department of Health and Mental Hygiene 2001 09726 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Dorothea Bentley 20 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore agnes HOSPITA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Unk 6. Sex **Funeral** 1 ☐ M 2 🗓 F 213-64-6805 50 Yrs June Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show Items 23a or 28a-f shov MD Baltimore Catonsville 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 55 Wade Avenue 21228 USA death Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ir than "natural", or Items the Medical Examiner of unk Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married unk 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) unk College (1-4or 5+) 17 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk Be of Health and Mental Hitem 27 is marked of 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) St. Agnes Hospital 900 Caton Avenue Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 🖾 Other (Specify) in State 21. Signature of Funer & Service Licensee Wade, State Anatomy Board 655 W. Baltimore Street Director nun xoul Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Immediate Cause (Final It cute my ocar DIMZ Due to (or as a consequence of): **Physician** MOI resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of): Examiner The law requires that the death certificate be executed monar signed by the attending physician and d be detached for use as the burial-trar Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) TYPS 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 🗆 Yes certificate 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X ÉR/Outpatient ပို 1 Yes 2 No 3□ DOA this 28c. Injury at Work? in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification; within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D22648 molin and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MARYLAND 2122 9 900 South Coton Avenue Jerome Snyder mp.
31. Date filed (Month, Day, Year) 22. Registrar's Signature State

Registrar

MAR 3 0 2004

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** March 28, 2004 12:37 a^M Bernard Joseph Baumiller, III /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb 7, 19 Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F **Funeral** Hours 54 Yrs. 215-58-3359 1950 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or Items 23a or 28a-f shorthe Medical Examinational Demotified at 1 ☐Yes 2 No Baltimore Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 111 West Road 21204 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) MD District Court al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Commissioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be fi Health and Mental H tem 27 is marked ot Bernard Joseph Baumiller, Jr. Mary Moynihan portment of Health and Mi portent: If item 27 is mark y injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Helen Baumiller/Sister 215 Ridge Avenue, Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Mar 30 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, MD * 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 permit.
Departn
Importe
any inju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives - Hulell 160984 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Septicem in **Physician** /Medical Due to (or as a consequence of): Examiner Endocarditi Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ysician and e burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has b autopsy performed? 1 Yes 2√2 No Vital To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MP ther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🐉 No Certification: To ð After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending 2 Accident investigation Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funerel Direct completely filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28305 March 28 2004 W Name and address of person who completed cause of death (Item 23a) (Type, Print) St Beltymore MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 3 0 2004 Registrar

3

State of Maryland / Department of Health and Mental Hygiene $2 \left(\bigcap_{i=1}^{n} \bigcup_{j=1}^{n} \right)$ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10:12 PM Month **Physician** 2004 March Breuning Bertha /Medical 4b_City, Town, or Location of Death County of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year If Under 24 Hrs. faltimore Franklin Hospital Quare Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 ☐ M 2 🗓 F Yrs. 88 217-26-7132 10, Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show item 27 is marked other than "natural", or items 23a or 28e-f show other treumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 9602 Amberleigh Lane Apt K 21128 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Š 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry should be filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th, Grade Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Silberzahn Nettie Fischer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m. any injury or othar treums 2005. Bertha Young/Daughter 9602 Amberleigh Ln. Apt K Perry HAll MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Moreland Mem. Park 3/31/04 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, 6415 Belair Road Baltimore 23a. Part1. Enter the dise shock, or heart fill are Immediate Cause (Final disease or condition resulting in death) is, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Respiratory ardio Physician /Medical Examiner stured Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed physicien and the burial-tran Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day for Month 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ∏ Yes 2 ∏ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a

To the Funerel I

completely filled filled 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Square Drive, Baltimore, MD 21237 9000 Franklin -Ghaida 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2004

Breuning, Bertha

		For State Registrar		nd / Depa	rtificate of	Death			2004	09729
Dhusiai		1. Decedent's Name (First, Middle, La					2. Date of De Month	ath Day	y Year	3. Time of Death
Physicia /Medic		Idabelle	Burdett	e	,		March	25	, 2004	3:05A M
Examin		4a. Fecility Name (If not institution, giv				r Location of Deat	h	4c.	County of Death	
<u> </u>		Collingswood Nu		last hirthdayl		ckville	8. Date of Bir		Montgome	
Funeral Director		5. Social Security Number 6. S	ox 2∑F 7. Age (#/y/s.	Yrs.	Months Days	Hours Min.		y, Year)		place (State or Foreign intry)
ii ector	1	215-14-2033 Usual Residence of Decedent	01				Whiti	14,1	722 I Una	vailable)
Mow at		10a. State 10b. County	1	ty, Town or Lo						10d. tnside City Limits
pelili	Completed by Funeral Director	Maryland Montgom	ery		Rocl	kville				1½ Yes 2 ☐ No
od other than "natural", or itama 23a or 28a-f ahow event, the Medical Examinar must be notified at	Olre	10e. Street and Number			10f. Zip Code			10g. Cit	izen of What Cou	intry?
TST	ral	299 Hurley Ave.	T			0850			ited Sta	
Diet	nue	11. Maritat Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.))~	 Race - American Bleck, White 	
ill di	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:			Specify:	White
a a	edic	15. Decedent's E	ducation	16a. Dece	dent's Usual Occur	pation		16b. K	ind of Business/Ir	ndustry
dedii	plet	(Specify only highest gra Elementary/Secondary (0-12)	ade completed) Cotlege (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	rking			
aumatic event, the M	E O		Unavailable)	(Unava	ailable)			(Una	vailable	e)
vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	, Maiden	Sumame)	
tic e	To E	(Unavailable)				(Unavail	able)			
BUTTE		19a. Informant's Name/Relationship (Type, Print)	19b. Maiti	ng Address (Street	and Number or R	ural Route Numb	er, City o	or Town, State, Zi	ip Code)
er tr		Sherry McIntyre/		401 H	ungarford	i Dr. 2nd				MD 20850
or of		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐		Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce) Marc	h 28	20c. Lo	ocation - City or T	own, State
uny		`4 □ Donation 5 □ Other (Special	(y) Che		ce Cremat		004		ltsville	, MD
any injury or other traumatic		21. Signature of Fungral Service tice	рsөө 11100.3	82 R	2. Name and Addre app Fune:	ass of Facility ${ al}$ al ${ al}$ Cr ${\epsilon}$	mation S	Serv	ices	
= 01		23a. Part1. Enter the disease, or com	mann	9	33 Gist <i>A</i>	Ave., Sil	ver Spr	ing,	MD 20	910
		shock, or heart failure. List only	one cause on each line.	ith. Do not en	ter trie mode or dyr	ng, such as cardia	c or respiratory a	iiesi,		Approximate Interval Between Onset and Death
ian ical		tmmediate Cause (Final disease or condition resulting in death)	a. Pneumonia							
er er		1	Due to (or as a conse							
	70	Sequentially list conditions,	b. Alzheimer Due to (or as a conse		ase					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· ·	,						
3	Exa	resulting in death) Last	C	quence of):						
the burial-transit	call	(d			. <u>-</u>				
for use as the										
nse	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr 1□Live birth 2□Fet		⊒Ectopic pregnanc	v			23d. Date of deliv	,
detached for u	sicla	in the past 12 months? 1 ☐ Yes 2 🎇 No	4 Pregnant at time of		Other (specify)	7			Month	Day Year
stache	hys	9 🗆 Unknown								
. 0		Part II. Other significant conditions		sulting in the u	inderlying cause gr	ven in Part I.				the cause of death?
should t	ted	Inflammatory B	owel Disease				1	Yes 2	□No 3□Pro	bably 4 XIUnknown
as or	Completed by						24a. Was	psy	24b. Were aut prior to co	opsy findings available ompletion of cause of
page	Con						perfo	ormed? 2 ∏ No	death?	
To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	Be (25. Was case referred to medical examiner?					ath (Check only	one)		
dire	2	1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2		III JUDON		т		6 ☐Other (Spec	ify)
nera Inera		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	Wo		28d. Describe	how intu	ry occurred	
the fi	cati	2 Accident investigation 3 Suicide 6 Could not be]Yes 2□No	204 1	·C++	- d M	
n by	THE STATE OF	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, si ify)	reet, factory, office		City or To	wn, State	nd Number or Rui 9)	ral Route Number,
Deli	Se	157 Octiving			4					
tely f	Medical Certification:		hysician: To the best of my kr miner: On the basis of examin and manner stated.							
mple	Mec	29b. Signature and titte of certifier	and mainer stated.		29c. Licen	se number		29d. Da	ite signed (Month	, Day, Year)
8		1.101	dman	mi		7801				
4	1	4 100		, 0	וכע	001		Mi	arch 26,	2004
h	1	30 Name and address of same	completed cause of death (the	m 23a1 /T	Print\					
h		30. Name and address of person who Aimee Seidman M.				th Potoma	ic. MD 3	20855	5	

HERMAN WESLEY CULLISON
Baltimore Marvland 21215-0036

	4
Box 68760,	
, P.O.	
Records	
Vital	
0	
Division	

	44		ype or Print in Bi State of Maryland	I / Depa		Health and M	Mental Hygi	ene	
Physicia		1. Decedent's Name (First, Middle, Last) Herman Wesle	y Cullison,		incate or	Death	2. Date of Death	Bay 2004	3. Time of Death
/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give single Carroll Hospital 5. Social Security Number 217–36–2549		st birthday) Yrs.	West	or Location of Death minster lif Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 21,	4c. County of Do Carre 9. E 1942	
<u> </u>	tor	Usual Residence of Decedent 10a. State 10b. County MD Carro1	10c. City,	Town or Lo	Westmin	ster			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
be filed within 72 hours after death with the Maryland Hygiene. Hygiene. A the Hygiene. A chief then "natural", or items 23s or 28s-f show event, i'm Medical Exar; is at rusal be notified at	Funeral Director	10e. Street and Number 197A Almyer Court 11. Marital Status 1 ☑Never Married 2 ☐ Married	2. Was Decedent Ever in U.S Armed Forces? 1Yes 2_MNo If Yes, Give	1	10f. Zip Code Was Decedent of If Yes, specify Cu 1 □ Yes 2 🗓 No	21157 Hispanic Origin? (Span, Mexican, Puerto		g. Citizen of What USA 14. Race - A Black, W Specify:	merican Indian,
Hygiene. Hygiene. Sther then "natural", or iteent, it is Medical Exercise.	Completed by	3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elementary/Secondary (0-12) 12	Year or Dates:	16a. Dece (Give life.	dent's Usual Occi	upation a during most of wor ed)		6b. Kind of Busine	ss/Industry
should be filed and Mental Hygi s marked other numatic event, II	To Be C	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Stree	18. Mother's Nan Ed:		ta Shame: City or Town, State	
permit. Pages 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any injury or other traumatic e once.		Ms. Betty Mahoney 20a. Method of Disposition 1 Description 3 Proceedings of the Companion Suppositio	20b. Pla	ace of Dispo metery, crei	osition (Name of matory or other p	Ct., Westi Cemetery	Date 2	MD 21157 Oc. Location - City Sykesvi1	
Departr Departr Imports any inje		21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complishock, or heart failure. List only on	Haight			UNERAL HOLLE, MD 21			Approximate
death certificate be executed A second of the second of t	ical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list condition of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ence of):	Cancer		9		Interval Between Onset and Death
thet the death certificate by led by the attending physic detached for use as the bi	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	□Ectopic pregnar			23d. Date of Month	delivery Day Year
s been sign s been sign should be	Completed by Pt	Part II. Other significant conditions con	tributing to death but not resu	alting in the u	underlying cause (given in Part I.		s 2 No 3	e to the cause of death? Probably 4 Llunknov autopsy findings availat to completion of cause of
Physicien: The la this certificate har ral director, page 2	o Be	25. Was case referred to medical examiner? 1 \sum Yes 2 \sum No	ospital: 1 Tripatient 2 1	ER/Outpatie	nt 3□ DOA		1 Yes 2 ath (Check only one tome 5 Reside	9)	Yes 2 1 1 10 Specify)
To the Hospitel or Attending Prily within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral or	Certification: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No						
o the Hospitel within 24 hours a to the Funerel Completely filled in	Medical Ce	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination Medical Examination (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or in	nvestigation, in m	y opinion, death occu	urred at the time, da	ite and place, and	due to the cause(s)
7		30. Name and address of person who co	0 0 1	23a) (Type	Print)	S2039	minista	March	29 200
Sta Regist		31. Date filed (Mark Pag Year) 2004	32 Registrar's Sigge		and I				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kiaun Cornish State of Maryland / Department of Health and Mental Hygiene State Unpend Item #23a-b,27,28a-i per me 631 5/25/14 tas Reg. No. 6 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 27 2004 Physician 952 AUN ам N15H /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland General Baltimore 8. Date of Birth (Month, Day, Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 100M 2□F 0 Director U P Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Exame an must be notified at 1 Tes 2 No Director BALFINEUR MAYLOW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with or Items 23e USB 2210 21217 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2. SHNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced naturel', Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: if item 27 is marked other than "n any injury or other traumatic—other than "n once. Elementary/Secondary (0-12) College (1-4or 5+) In front 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mason ပ UTHISH 19a. Informant's Name/Relationship [Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MASON MITHE LINDEN 210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eurgeral Service Licery Work a 240 BALLE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Asphyxia /Medical Due to (or as a consequence of): Examiner Overlay Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): as IF FFMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of autopsy /performed? death? 12 Yes 2 □ No Yes 2 \ No funeral director. Medical Certification; To After ie

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after decral Director: After within 24 hours at To the Funeral D filled

					1,4
25. Was case refe	rred to medical			26. Place of De	eath (Check only one)
examiner? M∑Yes 2 ☐ No		Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 🏂	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Dea 1 □Natural 2 X Accident	5 Pending investigation	J-2/-04	28b. Time of Injury 9:30 a M	28c. Injury at Work? 1 ☐ Yes 2 📉 No	28d. Describe how injury occurred overlay
3 Suicide 4 Homicide	6 Could not b determined		ome, farm, street, factory)	ory, office	28f. Location (Street and Number of Rural Boute Number City or Town, State) Baltimore, Mary Land
29a. Certifier	1 Certifying Ph	ysician: To the best of my kno	owledge, death occurre	ed at the time, date and place	ce, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

(Check only

one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number **OCME**

111 Penn Street, Baltimore, Maryland 21201

ompleted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year) March 28 2004

30. Name and address of person while JAGA

31. Date filed (Month, Day, Year) 82. Registrar's Signature

rocks

State Registrar

MAR 3 0 2004

State of Maryland / Department of Health and Mental Hygiene 2001, 1- State AMEND ITEM #8 PER FH G829 3/30/04 JHCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 25,2004 -AVINA aron /Medical 4b. Cily, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HOSPITAL MEMORIAL | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth JUL 04, 1919 Birthplace (State or Foreign (Month, Day, Year) | Country) | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country | Country UNION 7. Age (In yrs. last birthday). 5. Social Security Number **Funeral** 1□M 2XF Director UNIZNO WID Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 10a. State or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director MARYLAND Og. Citizen of What Country? 10e. Street and Number USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if tiem 27 is marked other then "neturelf, or iter any niqury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No f Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation นี้ N K N ะ นท (Give kind of work done during most of working life. DO NOT use refired) 16b. Kind of Business/Industry UNKNOW 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN 17. Father's Name (First, Middle, Last) しんだんじゅん 18. Mother's Name (First, Middle, Maiden Surname) UNKNEWN Be မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2026 E 3/57 ST. A (CARETAKER) LA TORAIN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2 Cremation 3 Removal from State 1 Buria 22. Name and Address of Facility

25 FORT HALL 4 □ Domation Other (Specify) 21. Sigrati ral Service Liceosee -ULTON AV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrespinck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or a consequence of): day Physician /Medical **Examiner** Due to (or as a confequence of) 44 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (er as a consequence of): use as the burial-tran the attending physician and Box 68760 the Kalenia Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an this certificate has autopsy performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: After t 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D46356 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21 Date fled (Month Day Vast) 22 Paristrate Signature 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 3 0 2004 State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Deeth 1. Decedent's Neme (First, Middle, Last) Physician Month 2007 Lillian Α Casto /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Security Number If Under 24 Hrs 8 Date of Birth (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Yeer) **Funeral** Days 1□ M 25 F Yrs. Sept. 11, 1919 West Virginia 235-54-1324 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10e State 10b. County show tem 27 is marked other than "natural", or flems 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Delaware New Castle Newark 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 148 Chestnut Crossing Drive 19713 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? I ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify Š 3 ☑ Widowed 4 ☐ Divorced White Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be fil.
Department of Health and Mental He
Important: if Item 27 is marked oth
any injury or other traumatic even Frederick Mitchell McClain Rose Belle Hess 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Beverly Miller / Daughter 148 Chestnut Crossing Drive, Newark, Delaware 19713 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) IOOF CEMETERY 3-27-04 Farmington, WV 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 I. Enturne risease, or comptic ions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final diseese or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examiner Sequentiatly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. or Attanding Physician: The law requires that the 1 Yes 2000 3 Probably 4 Unknown 1/1/when Š certificate has been signi rector, page 2 should be 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? 1 455 2 SNU 1 ☐ Yes 2 ☐ No s effer dearn.
ral Director: Affer this cerus.
s'in by the funeral director, pr 25. Was case referred to medical examiner? å 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 Yes 2 No 4∆ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Dey Yeer) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Attal within 24 hours efter der To the Funeral Directo completely filled in by th 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

Registrar

31. Date filed (Month, Day, Year) MAR 3 0 2004

29b. Signature end title of certifier



Ши

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

hard

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Donald H. Clifton /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street end number) Examiner Baltimore St. Agnes Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1⊠M 2□ F Yrs. 219-44-5964 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filad within 72 hours effer death with the Maryland Department of Health and Mantel Hygiens. Important: If them 27 is marked other than "natures", or items 23s or 28s-f show any injury or other treumstic event, the Medical Eventment. 10a State 10c. City, Town or Location MD Baltimore Catonsville Director 10f. Zip Code 10e Street and Number 13 Silk Tree Court 21228 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baitimore, Maryland 21215-0020 Š 3 ☐ Widowed 4 ☐ Divorced 69-71 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Ella Kathryn Coster Robert Gordon Clifton ဨ 19a. Informant's Name/Relationship (Type, Print) 19h Penelope Clifton/spouse 20a. Method of Disposition 20b. Place of cemeter 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5ĬOther (Specify) in state 21. Signature Funeral Service Licensee ROD 1 C S . Ward Director

art1. Enter the disease, or complications that caused the death. Do nock, or heart failure. List only one cause on each line.

ype, Print) L/spouse	15	9b. Mailing Address (Street and 13 Silk Tree (<i>Zip Code)</i> . 228
Removal from State) in state		of Disposition (Name of tery, crematory or other place)	Date	20c. Location - City o	r Town, State
Wade Dire	ctor	22. Name and Address of State Anatom	Facility y Board 655	W. Baltimore	Street
IXWU		Baltimore, M	D 21201		
lications that caused one cause on each line	the death. Do	o not enter the mode of dying, s	uch as cardiac or respirato	ory arrest,	Approximate Interval Between Onset and Death
ACUTE	EMX	COCARDIAL	15CHEMI	A	HR5

2. Date of Death

Day

10 2000

4c. County of Death

10g. Citizen of What Country?

USA

16b. Kind of Business/Industry

14. Race - American Indian,

Black, White, etc.

Specify: white

4:07A

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2√ No

unk

Maryland

Month MARCH

8. Date of Birth (Month, Day, Year Mar 27, 19

unk

Physician /Medical Examiner

Examine

Physician/Medical

þ

Completed

å

Certification: To

Medical

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

that initiated events resulting in death) Last	1 6	Due to (or as a consequence of):
	d	
Part II. Other significant con	ditions contri	ibuting to death but not resulting in the underlying cause given in Part I.

CORONARY ATHER OSCLEROSIS

Due to (or as a consequence of):

DANOMACOUS CORONARY

23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

YRS

24a. Wes an autopsy performed? 2 DNo

Home 5 ☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

eath (Check only one)

2 No

25. Was case referred to medical				26. Place of D
examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatient	3□ DOA	Other: 4 Nursing

1 ☐ Yes 2 27. Manner of Death 5 Pending investigation 1 Atlatural

6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a.	Certifier
	(Check only
	one)

2 ☐ Accident

3 Suicide

4 ☐ Homicide

Cartifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29b. Signature and title of certifie Work Media (Item 23e) (Type, Print) | DO037359 | MARCH 11, 2004 | 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) | KR15 M. 5HEKITKA, M.O.

29d. Date signed (Month, Day, Year)

EALTHCARE GOOCATON AVE BALTIMORE, MOZIZZG STAGNES 31. Date filed (Month, Day, Year)

State Registrar

MAR 3 0 2004



death.

aftar

Director:

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

filled in by

			1 - For State Registrar	State of	Maryland /	Depa Cer		t of H	ealth a				0 L	097	3 5
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Las Florence Clu 4a. Facility Name (If not institution, give	mp	ər)		4b. City,	Town, or	Location of		2. Date of Death Month March	Day .	Year 2004 of Death	3. Time of Deal	h M
	Funeral Director		713 14 3 17 1	HOME 7.	Age (In yrs. last t	birthday) Yrs.	If Under Months	Hmo 1 Year Days	NZ If Under 2 Hours	Min.	8. Date of Birth (Month, Day, August 30	Year) 0, 1912	9. Birthpl Count	ace (State or For try) (4-0)	eign
and 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28e-f ehow any injury or other traumatic event, the Medical Exams or must be redilled at once.	o Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County M.D. 10e. Street and Number SHUD HORATO RO 11. Marital Status 1 Never Married 2 Married 3 Horato 4 Divorced 15. Decedent's Ed (Specify only highest grave) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Charles Vincent	College (1-4	s: 16	13. V	Vas Deceding Yes, special Yes 2 Jent's Usua kind of word NOT us	I Occupa k done d e retired)	Specify: ution uring most	of working	cify Yes or No- lican, etc.)	Black Specify 6b. Kind of Bu Cloth laiden Surname	That Count A. America America K. White, e Black Siness/Ind	an Indian, atc.	
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: If tiem 27 is marke any injury or other traumatic.	To	19a. Informant's Name/Relationship (7 Filed & Clary 20a. Method of Disposition 1 Burial 2 Cremation 3 Charter 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	ype, <i>Print)</i> Removal from Sta	20b. Place	of Disportery, crem	Honey sition (Name natory or of Natural Name and	to of their place	nd Number	Conder Dis 3/340	- 0	City or Town, and D control of the c	2113 City or Tov	wn, State	
760,	Physician /Medical Examiner bhysician and bhysician and sthe purial-transit	cal Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. END Due to (or C.	n line.	e of):					respiratory arre			Approximate Interval Between Onset and Death	
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	ed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Part II. Other significant conditions co	4□Pregnan 9□Unknow	n 2	5	Ectopic pre Other (spe nderlying ca	ecify)	n in Part I.			Mon acco use contri	ibute to the	y Day Year e cause of death?	
of Vital Records,	Physicien: The lav r this certificate has ral director. page 2	n: To Be Completed	25. Was case referred to medical examiner? 1 Yes 2 No 27. Mann of Death	Hospital: 1 □ Inp 28a. Date of I	njury 28b	Outpatien . Time of		Bc. Injury	n 4 Mur	sing Hom	24a. Was an autopsy perform 1 Yes 2 //Check only one 15 Resider	ed? di (1) of 1	rior to comeath? Yes (Specify)		ible of
Division of	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attecompletely filled in by the fune	Certification:	1 Datural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	28e. Place of building	Injury - At home, etc. (Specify)	Injury farm, stre	M eet, factory	Work 1 □ Y , office	? ′es 2 □ N	21	8f. Location (Str. City or Town,	eet and Numbe State)	er or Rural		
)	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 29b. Signature and title of certifier	rsician: To the beiner: On the basi	s of examination a	ge, death and/or inv	estigation,	it the time in my op	inion, death	I place, au	d at the time, da	use(s) and mar te and place, a d. Date signed	nd due to	the cause(s)	
	₩ Ste	to-	30. Name and address of person who of the control o	Mor	of death (Item 23a	(Type)	V I	Par	KH	019	hts A	ve f	Balt	merg.	Y
DH	Registi 1MH 17 Rev 1/2	ar	MAR 3 0 200	10	wo the	As	of I		<u></u>						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Year March 27, 1:43 p M William Charles Collurafici **Physician** /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Perryville 34 Carpenters Point Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1₩ 2□ F 213-34-8793 65 May 1, Maryland Director Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State wode 10b. County "natural", or Itama 23a or 28e-f ehov digal Examiner must be notified at 1 ☐ Yes 3 ☐ No Perryville Director Maryland Cecil 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21903 U.S.A 34 Carpenters Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If ¥es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after. Health and Mental Hygiene. em 27 is marked other than "natural", or Ital ither traumatic evant, the Mudical Examinal 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white Baltimore, Maryland 21215-0036 ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) John D. Lucas Printing Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Quinn Vincent Collurafici 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is.
any injury or other trau 34 Carpenters Point Road Perryville, Maryland 21903 Lena Youngblood-daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ACremation 3 ☐ Removal from State 3/31/04 Laurel, Maryland 4 □ Donation 5 □ Other (Specify) Baltimore/Wash. Crem 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Pant Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MONTH LUNG CANCER METASTATIL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 | Fetal death 3 Ectopic pregnancy Day Month in the past 12 months? for 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by 23e. Did tobacço use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 3 ☐ Probably 4 ☐ Unknown 1 PYes 2 No Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 2 No 2 No 1 Yes 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3□ DOA 1 Inpatient 2 ER/Outpatient Certification: To 1 ☐ Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after death. Funeral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 11/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. To the F the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00047711 MARCH 29,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite #3 ELATION MARYLAND 304-306 North Street DAVID GAL-RL 32. Registrar's Signature 31. Date filed (Month, Day, Year) Books State MAR 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 2:10 pm 24 2004 JOHN DILABIO MARCH 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) VA BALTIMORE BALTIMORE CENTER MEDICAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 4/13/48 5. Social Security Number 6. Sex 1 DM 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary and 216-52-3884 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Upper Marlboro Prince George Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 USA 10 Main Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1X Yes 2 □ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bielzwski Dilabio Unknown Unknown 19a. Informant's Name/Relationship (Mpe 17cal Center 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 North Greene Street Baltimore, Md. 21201 Dept. Veterans Affairs 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ Removal from State 3/29/04 Crownsville, Md. Md. Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stallings Funeral Home PA 21. Signature of Funeral Service 3111 Mountain Rd. Pasadena, Md. 21122 Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the shock, or heart fa sease, or complications. List only one Immediate Cause (Final diseese or condition resulting in death) 6 yrs. CARDIOMYOPATHY ICHEMIC Due to (or as a consequence of) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury n in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probabty Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 10 Yes 2 110 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examine Hospital:

by Physician/Medical Examiner To the Funeral Director: After this certificate has been signed by the attending physician end compietely filled in by the funeral director, page 2 should be deteched for use as the buriel-trensit Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760. Be Completed Medical Certification: To s efter death.

Physician

/Medical

Examiner

Physician

/Medical

Examiner

Funeral

Director

permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evandret must be notified at

Baltimore, Maryland 21215-0020

Be Completed by Funeral Director

that initiated events resulting in death) Last	Due to (or as a consequence of):
	d
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause give

12€ Yes 2□	No	1 Inpatient 2	ER/Outpatient	3□ i	DOA	4 ☐ Nursing F	lome 5 Residence 6 ☐ Other (Specify)
 Manner of Death Manner of Death Matural Accident 	investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stree fy)	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number P17668 29d. Date signed (Month, Day, Year) 3/24/2004

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CHRISTINE HUYNH, M.D. 10 N. GREENE STREET, BALTIMORE, MD 21201

31. Date filed (Month, Day, Year) State Registrar MAR 3 0 2004

29a. Certifier

32. Registrar's Signature

DHMH 16 Ray 6/95

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To the Hospital of within 24 hours of To the Funeral D

			1 - For State Registrar	State of Ma		artment of F		Mental Hygie	ne No. 2004	09738
	Physici	an	1. Decedent's Name (First, Middle, Last)	aret E.				2. Date of Death Month	Day Yeer	3. Time of Death
	/Medio Examir		4a. Fecility Name (If not institution, give so	treet and number)	Dudek	_	r Location of Deat	h	6 2004 4c. County of Deeth	
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday, 79 Yrs.		If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Ye March 2,	Baltimor 9 Birth 200 1925 Mar	olace (State or Foreign
	e Maryland a-f show	ctor	10a. State 10b. County MD Baltim		10c. City, Town or L		sex			10d. Inside City Limits 1 ☐ Yes 2X No
	th with the 23a or 28	Funeral Director	10e. Street and Number 308 Poplar Road	l		10f. Zip Code 21 2 2	21	10g. US	Citizen of What Cou	ntry?
036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show he Medical Example in that be notified at	by	11. Marital Status 1 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 Yes 2 No ff Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (S in, Mexican, Puer Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify.Whi	etc.
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yland;	should be filed ind Mental Hygi s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Joseph Mroz				Eva G	ne (First, Middle, Maid ulczynski		
Baltimore, Maryland 21215-0036	Pages 1 and 2 sho nent of Health and int: If item 27 is m iry or other traum		19a. Informant's Name/Relationship (Type Anthony Dudek S 20a. Method of Disposition 1	r./husba	and 308	Poplar osition (Name of matory or other place	Road Ba	_		own, State
Baltiı	permit. Pages Department of H Important: If ite any injury or of		21. Signature of Funeral Service License	onne	lly 2	2. Name and Addres	ss of Facility Co	nnellyFu Baltimo	neralHom re MD 21	eofEssex 221
	Physician /Medical Examiner	ler	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one famediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury the interest of the shock of the sh	Due to (or as a	hal In	ter the mode of dyin		or respiratory arrest,		Approximate Interval Between Onset and Death
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۵.	w requires that the been signed by should be detact	þ	Part II. Other significant conditions cont	ributing to death but	not resulting in the c	inderlying cause give	en in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death? ably 4 □Unknown
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Division o	Attending Ph ir death. ector: After th by the funeral	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day	Year) 28b. Time o	Work		28d. Describe how in		
DİVİ	i gi te		4 Homicide determined	building, etc.				City or Town, St		
	To the Hospitel within 24 hours of To the Funeret I completely filled	Medicai	29a. Certifier (Check only one) 1 Medical Examination one) 2 Medical Examination one) 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination on one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination one of the certifier 1 Medical Examination on the certifier 1 M	er: On the basis of e and manner state	examination and/or in	n occurred at the firm evestigation, in my op 29c. License	pinion, death occu		and place, and due to Date signed (Month,	the cause(s)
	H 3 F 8		30. Name ago address of person who con	noleted cause of do	ath (Item 23a) (Type			Altimore N	•	
)	<i>y</i>		Jones 15 Cu	^	Signal a	th Wolfe	Stret	Altimore	Pkrykn	21287
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State of Maryland / Department of Health and Mer	al Hygiene 2 () ()

			For State Registrar	State of I	Marylan		artment of H tificate of				giene Reg. No.	200	+ 09739	3
	Physici		1. Decedent's Name (First, Middle, Last	ECUBE	1110					2. Date of Dea Month MARCH	Day	The Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give Northwest Hospita	street and numb	er)		4b. City, Town, o Randal		of Death	r IIINCII	4c.	County of De Balti		
2000	Funeral Director		5. Social Security Number 6. Se 213-18-5102	x 7. □ M 2□XF	Age (In yrs. I 85	last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birtl Month, Day Sept.	y Year)	.918 ^{9. B}	nthplace (State or Foreign Country)	1
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	with the	i Director	10e. Street and Number 3801 Schnaper Dr:	ive #131			10f. Zip Code	133			-	zen of What C	Country?	
36	s after deeth , or Items 2: arch at traus	y Funera	11. Marital Status 1 Never Married 2 Married 3 🖫 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2	ent Ever in U. es? No		Was Decedent of F f Yes, specify Cub	lispanic Or an, Mexica Specify		ify Yes or No- lican, etc.)				_
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show feuratic event, Ins Medical Exacting transit for notified at	Completed by Funeral	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			(Give	tent's Usual Occur kind of work done OO NOT use retire	during mos d)	st of workin	g	16b. Kii	nd of Busines	s/Industry	_
and 21	og a b ≥	o Be Con	17. Father's Name (First, Middle, Last) Samuel Geor				Superviso	18. Moth		(First, Middle, Davis		kbindi Sumame)	ng	
Mary	12 shoul h and Me 7 is mark treumati	P.	19a. Informant's Name/Relationship (T)	pe, Print)	-	1	g Address (Street	and Numb	er or Rural	Route Numbe	-			
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Balt	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licens Summary License Licen		ilt	HÃ	Name and Addre IGHT FUE kesville	NRAL	HOME	& CHAP	EL.	PA (Bo	•	
V.	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on eac	the death line.	n. Do not ent		ng, such as	s cardiac or	respiratory ari	rest,		Approximate Interval Between Onset and Death	
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rds, P.	The law requires that the tee has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions co	ntributing to deat	h but not resu	ulting in the u	nderlying cause giv	en in Part	1.		bacco u es 2[to the cause of death? Probably 4 AUnknown	
Vital Records,		Completed								24a. Was a autop: perfor 1 Yes	sy	24b. Were a prior to death?		
	nysician: Th	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🔀 Inp	atient 2 🗆	ER/Outpatien	t 3 DOA Oth			(Check only or e 5 ☐ Resid		S □Other (Sp	ecify)	
Division of	ding Pt n. After th funeral		27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c, Injur Wor M 1		28	3d. Describe h				
DIX	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place ol building,	Injury - At ho , etc. (Specify	ome, farm, str	eet, factory, office	7-1	28	3f. Location (S City or Tow	treet and n, State)	d Number or F	Rural Route Number,	
	To the Hospitel or A within 24 hours after To the Funerel Direction plately filled in by	edicai	29a. Certifier Certifying Phy (Check only one)	sician: To the be ner: On the basi and manner	s of examinat	wledge, death tion and/or in	occurred at the tir restigation, in my d	ne, date ar pinion, dea	nd place, ar ath occurred	nd due to the c d at the time, o	ause(s) late and	and manner a place, and du	s stated. e to the cause(s)	
	To t withi	W	29b. Signature and title of certifier	mul	la m	0.	29c. Licens		410	1		signed (Mor	th, Day, Year)	
	1/		30. Name an ordra's of person who co	ompleted cause	ol death (Item	- 4	Print) LOG BAMONI			MEH-				
	Sta Regista	-	31. Date filed (Month, Day, Year) MAR 3 0 2004		istrar's Signa		1							

			State of Maryland / Departn		-	_	
			- FOI	cate of Death		2004 (09741
	Physici	22	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Yeer	ne of Death
	/Media	al	PAUL DUNMYER	City Town or Location of Death	MAR		247 PM
1	Examir	er	4a. Fecility Name (If not institution, give street and number) 4b. HOWARD (OUNTY GENERAL HOSPI)	City, Town, or Location of Death	1410	4c. County of Death	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Under 1 Year If Under 24 Hrs. Inths Days Hours Min.	8. Date of Birth (Month, Day,		tate or Foreign
	Director		210-09-3296 XM 20 85 Yrs.	IIIIS Days Flours Wist.	JUNE 1,	1918 Pennsyl	
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	1		10d. Insid	de City Limits
	Mary a-f sh	to	Maryland Howard Ellicott Ci	ty		10	Yes 2 No
	or 28	Direc		of, Zip Code		g. Citizen of What Country?	
	s 23a	rai		1042		SA 14. Race - American India	
ĽΩ	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	by Funeral Director	1 Never Married 2 Married 1 Mayes 2 No 1942-	Decedent of Hispanic Origin? (Spe , specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White, etc.	
21215-0036	ours a	d by	3 Widowed 4 Divorced Year or Dates: 1943	es 25 No Specity:			hite
15-	in 72 h n nati	Completed	(Specify only highest grade completed) (Give kind life, DO N	Usual Occupation of work done during most of workii OT use retired)	ng 1	6b. Kind of Business/Industry	
212	d with giene. er the	mo.	Elementary/Secondary (0-12) College (1-4or 5+) Ground M	laintenance	F	ederal Governm	ent
	12 should be filed within hand Mental Hygiene. 7 is marked other than "Iraumatic event, the Mer	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		uden Sumame)	
Maryland	d Men narka natic	5	John F. Dunmyer 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Ad	Margare dress (Street and Number or Rura		City or Town State Zin Code	
Ma	nd 2 slith an 27 is r			rederick Road			042
Je,	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 1 ☐ Burial 2 反 Cremation 3 ☐ Removal from State	(Name of prother place)	ate 2	Oc. Location - City or Town, Stat	te
Baltimore,	Pa ant: ury		'4 □Donation '5 □Other (Specify) Metro Crema	tory Inc. 3-27		altimore, MD	
Bal	permit. Pages 1 and 3 Department of Health Important: if item 27 any Injury or other tra		21. Signature of Fungral Service Licepseed 22. Nar Cre Thomas Gregor 299	ne and Address of Facility emation Society Frederick Road	of MD, I Ba l ti	nc. more, MD 2122	8
			23a. Part1. Enter the disease, or complication that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	mode of dying, such as cardiac o	r respiratory arres	t, Approx Interval	rimate Il Between and Death
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	OCK			AYS
	Examiner		Due to (or as a consequence of): Sequentially list conditions,	WALL ABSC	FSS	31	WEEKS.
	n =	ner	if any, leading to immediate Due to (or as a consequence of):				CORS.
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	VERTICULITIS	•	21	veeks
760,	sician buria	cal E	d d				
89	tificate ng phys as the		,				
Box	ath cer ttendir or use	an/		pic pregnancy		23d. Date of delivery Month Day	Year
P.O.	that the death certificat ed by the attending phy detached for use as th	Physician/Medi	1 Yes 2 No 9 Unknown	er (specify)			
	s that med b	y Pł	Part II. Other significant conditions contributing to death but not resulting in the underly	ring cause given in Part I.	23e. Did toba	cco use contribute to the cause	e of death?
ord	w requires that s been signed to should be det	ted	CORONARY ANTERY DISTASE		1 🗆 Yes	2 No 3 Probably 4	4 🗷 Onknown
Division of Vital Records,	e law thas be	Completed by	CARDIAL ISCHEMIA		24a. Was an autopsy performe	24b. Were autopsy findi prior to completion death?	ings available of cause of
al	n: Th flicate or, pag	e Co	ATPIAL FIBRILLATION 25. Was case referred to medical	OS Blace of Booth	1 Yes 2	2No 1 ☐ Yes 2 ☐ No	
Ξ	ysicle is cert directo	To Be	examiner? Hospital:	26. Place of Death ☐ DOA Other: 4 ☐ Nursing Hor		ce 6 ☐Other (Specify)	
0 0	ng Ph Ifter th Ineral	on:	27. Manner of Death 28a. Date of Injury 28b. Time of (Month, Day Year) 28b. Time of Injury	Work?	8d. Describe how	injury occurred	
isio	ttendi death. :tor: A : the fu	icati	2 Accident investigation 3 Suicide 6 Could not be		PRI Location (Stre	et and Number or Rural Route	Number
Div	afor A after 1 Direct d in by	Certification:	4 Homicide determined building, etc. (Specify)	ictory, onice	City or Town,	State)	rearriger,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occi 2 Medicel Examiner: On the basis of examination and/or investigand manner stated.	urred at the time, date and place, a pation, in my opinion, death occurre	and due to the cau ed at the time, dat	se(s) and manner as stated. e and place, and due to the cau	ise(s)
	To the To the comp	ž	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Yea	ar)
	, 11		> Hunding nip	142892		MAR 26 1	004
	14.		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANCIS CHUDIAN 10724 LITTLE PAT	EXENT PARKI	144 CO	ELVMBIA MID	SIRULI
	Sta	ate	31. Date fill April 90ap Year 04 32. Registrar's Signature	17000 11)1	vn 7	Will little	01040
	Regist	rar	TOUT JOHN STORES				

Dickinson, MonJohie Baltimore, Maryland 21215-0036

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							Cei	fificate of	Death	2. Date of Dea		2004	7 1	
	Physicia /Medic		1. Decedent's Name (Fine Marjorie	E.	Dickinsor	1				Month	Day	\$ 2 mo	3. Time of Death 5:15 A	Α
	Examin	- 1	4a. Fecility Name (If not)	institution, give	<u> </u>	1051	Pital	4b. City Town, o	r Location of Death	e	4c. G	ounty of Death	non	2
	Funeral Director		5. Social Security Number 173-09-297	er 6. Sex	7. Age	(In yrs. 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 20	, Year) ,1907	9. Birth	place (State or Foreigntry) th Africa	n
7			Usuel Residence of Deci	edent			y, Town or Lo						10d. Inside City Limits	
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the A	28e-	Director	Maryland Ba	at criiior e		1 6	3T KATT1	10f. Zip Code			10g. Citize	n of What Cou		
die.	23a or		8820 Walt	ther Blv	∕d.			21234			L	JSA	_	
allylation & I.E. 13-0000	"naturel", or items 23a or 28e-f ahov polical Exambar must be ricilified at	/ Funeral	11. Marital Status 1 ☐ Never Married	2 Married	12. Was Decedent E Armed Forces? 1 Yes X			Was Decedent of F f Yes, specify Cub- 1 ☐ Yes 2 ☑ No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)		Race - Ameri Black, White,	etc.	
	urel',	d by	3 XWidowed 4 □		Year or Dates:			dent's Usual Occur	nation			اللا I of Business/Ir	nite	
2	ntal Hygiene "naturid of the control of the control of the medical of the control	Completed	(Specify or Elementary/Secondary	Decedent's Edu nly highest grad	cation e completed) College (1-4or 5		(Give	kind of work done DO NOT use retire	during most of work	king	100, Kind	I OI BUSINESS/II	dustry	
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) y	and Mental Hygiene. is marked other than sumatic event, tra Ms	은	Lawrence	J. Relationship (Tv	Mc Caffre	ЗУ	19b. Mailir	ng Address (Street	Anne E			IV İS Town, State, Zii	p Code)	
	yes I and 2 should to thealth and Mer If item 27 is marks or other traumatic		Cecily Rose H	aeger Haeger	/ Daughter	•			dica Loop					
. ע	perfilt. Fages Faring Department of Health a importent: If item 27 is any injury or other tra		20a. Method of Disposition		lamoval from State	20b. P	Place of Dispo	sition (Name of matory or other pla	сө)	Date	20c. Loca	tion - City or T	own, State	
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סמ	Departr Import any inj		21. Signature of Fune al	1 Servic Licens				2. Name and Addre	ess of Facility In Funeral	l Home		050 You		
5	- Age		23a. Part1. Enter the dis	sease, or compl	icate s that caused	the deat						000011,1	Approximate Interval Between	
Р	hysician		Immediate Cause (Final disease or condition		+501	a	tan	Pha	Man.	A			Onset and Death	
	/Medical xaminer		resulting in death)		Due to or as	a conseq	uence of):			(-				
	.xammer	ž	Sequentially list condition	ons,	Due to (or as	a conseq	uence of):							
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0 / 00	physic the bu	dlca			d									
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	wrequires trait in beauti certificate been signed by the attending physis should be detached for use as the t	Physician/Medical	23b. Was decedent pred in the past 12 men 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ths?	1 □ Live birth 4 □ Pregnant at 9 □ Unknown			Ectopic pregnancy Other (specify)	у			Month	Day Year	
cords, r	n signed build be deta	by	Part II. Other significan	t conditions co	ntributing to death b	ut not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to 1 □ Y	_		the cause of death? bably 4 □Unknow	ח
222	itte raw requires that the beaut certificate the has been signed by the attending phys bage 2 should be detached for use as the	Completed								24a. Was a autop: perfor	sy	24b. Were auto prior to co death? 1 \(\sum Yes\)	opsy findings available ompletion of cause of	9
	ortifica ctor, p	BeC	25. Was case referred to examiner?	o medical					26. Place of Dea	th (Check only or			20110	
5	r this certific ral director,	2	1 Yes 2 No	ŀ	Hospital: 1 Inpatie		ER/Outpatier	IL SEL DUA		ome 5 Resid			(y)	
	After funer	tlon:		Pending investigation	28a. Date of Inju- (Month, Day	y Year)	28b. Time of Injury	Wo	ryat rk?]Yes 2 □No	28d. Describe h	ow injury o	occurred		
IVISI	ter deat irector: by the	Certification:	2 Accident 3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Injubulding, etc	ury - At he	ome, farm, str (y)	reet, factory, office		28f. Location (S City or Town		Number or Run	al Route Number,	_
ב ב	to the hours after distraining rivercent. The far within 24 hours after door within 24 hours after the fire this certificate has completely filled in by the funeral director, page 2.		29a Certifier 12	Certifying Phy	sician: To the best	of my kno	owledge, deat	h occurred at the ti	me, date and place	, and due to the c	ause(s) ar	nd manner as s	stated.	
	the Futher Polymers of the Futher Fut	Medical	one)		ner: On the basis of and manner sta		ition and/or in							
	To To	2	29b Signature and title	of certifier				1 O (594	113 =	3	signed (Month,	Jay, Year)	
	17		30. Name and address	of person who co	ompleted cause of d	eath (Iten	n 23a) (Type,	Print)	-	203		9		
	1		31. Date filed (Month, D		32 Registra		Tank	11n 50	mare,	Vivel	30/17	-imple	ml 2/2	37
	Sta Regist		MAF	3 0 201		ه من منها المنهادة	J. A	seal!						

2022		For State Registrar	State of Maryland / Depa Cea	artment of Health and N rtificate of Death	ental Hygie Rea.	ne 2004	09742
Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 22, 2004	3. Time of Death
/Medi Examii		Merrill Edward Dri 4a. Facility Name (If not institution, give str ST. AGNES HOSPITAL		4b. City, Town, or Location of Death BALTIMORE CITY	TIAITON 2	4c. County of Deeth	1037 A
Funeral Director		215-46-9203	7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Jan 18,	9. Birthp	
laryland ahow	ō	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
with the N 3a or 28a-f	Direct	MD n/a 10e. Street and Number 2536 Washington Blv		10g. Citizen of What Country? United States			
Baltimore, Maryland 21215-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any highry or other traumatic event, Ita Medical Exams or must be notified at once.	Completed by Funeral Director		. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Non a 2 0 / 6 5	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
Z I Z I D-UUJO d within 72 hours aft giene. ar than "natural", or	mpieted	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion 16a. Dece	dent's Usual Occupation kind of work done during most of work DO NOT use retired) VMA1	ing 16	b. Kind of Business/Ind	dustry
Mal ylailu & d 2 should be filed v th and Mental Hygie 27 Is markad other traumatic event, II	To Be Co	12 17. Father's Name (First, Middle, Last) Broening H. Driver	Italia	18. Mother's Nam	e (First, Middle, Mar		
Tand 2 sho Health and I tem 27 Is me		19a. Informant's Name/Relationship (Types Pamela J. Marvin / 20a. Method of Disposition	freind 1914	ng Address (Street and Number or Rur 4 Letitia Ave. Bal position (Name of matory or other place)	timore, M		230
permit. Pages 1 ar Department of Hea Important: If Item any Injury or othe once.		1 ⊠ Burial 2 □ Cremation 3 □ Rer 4 □ Denation 5 □ Other (Specify) 21. Signature of Funeral Struce Licentee	0/2004 Cr prose Fune	cownsville, eral Home o	Maryland of Lansdow		
Physician /Medical		23a. Part 1. Enter the disease, or empiles shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. Do not en	2719 Hammonds Ferr ter the mode of dying, such as cardiac Cook to Vojcilor	ry Rd. Lar or respiratory arrest	nsdowne, Ma	ary 1 and 21 Approximate Interval Between Onset and Death
cate be executed was physician and minimal-transit to	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):				
that the death certifical ed by the attending photelached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ory Day Year
requires that the een signed by the	þ	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	A-1
The law ate has page 2 st	Completed				24a. Was an autopsy performed 100 Yes 2	d? prior to coi	psy findings available apletion of cause of 2 No
ing Physician: The After this certificate funeral director, pag	n: To Be	27. Manner of Death	spital: 1 Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	nt 3∑ DOA Other: 4 Nursing Ho	h <i>(Check only one)</i> ome 5 Residenc 28d. Describe how	e 6 Other (Specify	r)
To the Hospital or Attending within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide determined	28e. Place of Injury · At home, farm, st building, etc. (Specify)	M 1 Yes 2 No	28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,
To the Hospital or Attend within 24 hours after dealt To the Funaral Director: completely filled in by the	edical	29a. Certifier (Check only 20 Medical Examine	cian: To the best of my knowledge, deat r: On the basis of examination and/or in and manner stated.				
To t withi To ti	M	29b. Signature and title of certifier	40	29c. License number OCME		Date signed (Month, RCH 23, 20	
h		30. Name address of person who com 31. Date filed (Month, Day, Year)	pleted cause of death (Item 23a) (Type, 111 Registrar's Signature	Penn Street, Balt	imore, Ma	ryland 212	01
St Regist	ate trar	MAR 3 0 2004	Academy of the second	all I			-

State of Maryland / Department of Health and Mental Hygiene 2004 09743 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2004 March 26, 8:45 A Sadgun Dave /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laurel Regional Hospital Laurel 8. Date of Birth (Month, Day, Year) April 8,1918 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. 1 □ M 2 🖾 F 85 Yrs. India Director 214-17-4928 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23s or 28s-f show the Medical Examinar must be coulded at 1 ☐ Yes 2 No Directo Maryland Montgomery Burtonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20866 3020 Novak Terrace India Funera 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ☐Yes 2 No 1 ☐ Yes 2 X No Specify: Specify: Asian Indian δ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be lift Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2002: Be Pathak Suraiben Pathak Umivasankar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3020 Novak Terrace; Burtonsvillen, MD Bipin N. Dave / Son Date 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2004 Chesapeake Crematory Beltsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Moo382

22. Name and Address of Facility Rapp Funeral and Cremation 933 Gist AVe., Silver Sprin

23a. Parl Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility
Rapp Funeral and Cremation Services 20910 933 Gist AVe., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumonia 3 days **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🎇 No 4☐ Pregnant at time of death 5 Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Diabetes page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension has certificate 1 Yes 2√ No Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No М within 24 hours after death. To the Funeral Director: A investigation the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 4 Homicide pelli Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifiei Medical completely (Check only one) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D23181 March 26, 2004 T h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R.G. Bhojras, M.D.; 704 Gorman Ave. #T-1; Laurel, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature About ! MAR 3 0 2004 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0834 AM 03 2004 27 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospital andallstown MD 21136 Baitimore Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 M 2 F 72 625-54-7054 Director 0206 1932 ietnan Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 23s or 28a-f show the Medical Examiner must be notified at Reisterstown Baltimore 1 ☐ Yes 2 No MD Director 10g. Citizen of What Country? Vietnam 10f. Zip Code 21136 10e. Street and Number 408 Shirley Manor Road, Apt. Tl death 1 14. Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2X No If Yes, Give 1 Never Married 20 XMarried Vietnamese Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 9th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked i any injury or other treumatic ev Nhu Nguyen Thiem Nguyen 9b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 408 Shirley Manor Road, Apt. TI, Reisterstown, MD 19a. Informant's Name/Relationship (Type, Print) Husband Duong Do 21136 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition All Saints Cemetery Reisterstown, MD tx Burial 2 ☐ Cremation 3 ☐ Removal from State 4/30/2004 * 4 ☐ Donation 5 ☐ Other (Specify) 11824 Reisterstown Road 21. Signature of Juneral Service 22. Name and Address of Facility Kulwill ELINE FUNERAL HOME Reisterstown, MD 21136 Part 1. Enter the sease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the Immediate Cause (Final **Physician** · ARSERITSCLEROS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 1 DURT HWEST NEGOTIAL CENTER CLIFFTAD FABER RANDALLSTYNN MARYLAND 31. Date filed (Month, Day, Year) MAR 3 0 2004 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician March 20, 7:45 AM M 2004 Okiey Easter Elliott /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Bel Air Jacob Well Assisted Living ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1X M 2 □ F March 27, 1921 Virginia Director 212-22-0502 82 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rel', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Funeral Director Maryland | Harford Bel Air 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 522 Thomas Run Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced "neturel" ar than "neture the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Farmer Farming 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Other Clarence Elliott Belle Georgie Mabes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other treu <u>once.</u> Roy G. Elliott / Brother 1002 Main Street, Darlington, MD 21034 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1- Burial 2 ☐ Cremation 3 ☐ Removal from State Deer Creek Harmony Pres. 3-23-04 Darlington, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Ser McConas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 my from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate interval Between Onset and Death 23a. Pert1. Enter the disease, or complications, or heart failure. List only of Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months detached for 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. g 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed' 2 □ No 1 ☐ Yes 211 To the Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) stee Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 ther (Specify 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA Medical Certification; To this neral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner - ceath 1 Unatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide ī 💟 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medicel Examiner: On the resist of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and may ner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Linda Freilich son who completed cause of death (Item 23a) (Type Print) 30. Name and address of pe 101 Wall 31. Date filed (Month, Day,) 32. Registrar's Signature State Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

32. Registrar's Signature

JACK M. TITUS

31. Date filed (Month, Day, Year)

MAR 3 0 2004

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

March 27, 2004

			1 - For State Registrar	State of M	laryland / Depa	artment of F rtificate of	Health and <i>Death</i>	Mental Hy	giene 2	004	09747	
	Physici	an	Decedent's Name (First, Middle, L LAURA ELLEN GI					2. Date of De. Month MARCH	ath Day	Yeer	3. Time of Death	
	/Medio		4a. Fecility Name (If not institution, g)	4b. City, Town, o	or Location of Dea		1	2004 ty of Deeth	7:50 A.M	
	LAdiiiii	CI	6660 LOCH HILL F			LOCH H				TIMORE	ō	
	Funeral				ge (In yrs. last birthday)	If Under 1 Year Months Days			h		lace (State or Foreign	
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	land		10a, State 10b, County		10c. City, Town or Lo	cation				10	Od. Inside City Limits	
	Man B-f sh	tor	MD BALTIMO	DRE	LOCH HI	LL					1 ☐ Yes 2 ☐ No	
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	ath w		6660 LOCH HILL F			21239			USA			
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heatth and Mental Hygiene. ortant: If Item 27 is marked other than "naturst", or Items 23a or 28a-f show injury or other traumatic event, Ita Medical Examiner must be notified at its.	by Funeral									an Indian, etc. E	
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	7		30. Name and address of person who	completed cause of	death (Item 23a) (Type, I	Print)	fora,	MI	2/13			
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			For State Registrar		State	of Marylar	nd / Depa <i>Cei</i>	artment <i>rtificate</i>	of H	ealth D <i>eath</i>	and M	lental Hy	/gien Reg. N	e 20	104	09748
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	/Medic Examin		4a. Facility Name (If not institution	give street and n	umber)		4b. City, T	own, or	Location	of Death		40	c. County	of Death	
	LXCITIII	ŭ.	Wesley	Nursing	Home			В	alti	more	:					
	Funeral		5. Social Security N		6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Months	Year Days	If Unde	r 24 Hrs. Min.	8. Date of Bi (Month, D	rth av Year	r)	9. Birthpl	ace (State or Foreign try)
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Division of Vital Records, P.O. Box 68760.	Physician: The law requires that the death certifi this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/M			and contributing to	death but not re	eulting in the	ınderlying ca	IIISA AIVA	en in Part	1	23a. Did	23e. Did tobacco use contribute to the cause of death?			
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	9		30. Name and add	TLIBE	who completed ca	3508 B	em 23a) (Type	, Print)	BAZ	-70,	me	212	24	6		
	Sta Regist		31. Date filed (Mo	MAR 3 0	who completed cardo, www.	Registrar's Sign	nature	and		,						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day **Physician** Katherine Elizabeth Grim March 27, 2004 7:10 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Fecility Name (If not institution, give street end number) Examiner Charlestown Care Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2XF Yrs 95 MAR 9, 1909 Director 213-09-8414 Maryland Usuet Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland nant of Health end Mentel Hygiene. Int: If Item 27 is marked other than "naturel", or Items 23s or 28e-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Catonsville rms 23s or 28e-fir 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 701 Maiden Choice Lane 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Merried 2 ☐ Merried 6 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant School School 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Be ၉ Frederick Grim Catherine Ball 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health el Important: If Item 27 is eny Injury or other trau Mary Blair/Niece 623 Wallerson Road Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Loudon Park Cemetery 3-31-04 Park Cemeter,

22. Name and Address of Facility
MacNabb Funeral Home, P.A.

Catonsville, MD Baltimore, MD 21. Signature of Funeral Service Licens 21228 Edward A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed paga 2 s 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 27. Mainner of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 🗆 No To the Hospital or Attend within 24 hours after deeth To the Funeral Director: / completely filled in by the f 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Mopth, Dey, Yeer) 29b. Signature and title of certifier 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) vanu 100

DHMH 16 Rev 6/95

State

Registrar

gistrer's Signature

2004

					State of Maryl	and / Depa	artment of I	Health and M	-	giene .	
				1 - State Registrar		Ce	rtificate of	Death		Reg. No. 200	. 93100
		Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
		/Medi		Mamie Giudic 4a. Facility Name (If not institution, give s			4h Cihi Tourn	or Location of Death	March	28, 2004 4c. County of De	2:30 P M
	1	Examir	ner	Oak Crest Care C			Parkvi			Baltim	
		Funeral		5. Social Security Number 6. Sex	7. Age (In)	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day		rthplece (State or Foreign Country)
		Director		217-05-4880	M 2⊠F 88	Yrs.	Worths Days	Hours Min.	April 1	2, 1915	Colorado
		land		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
		Mary I sh	ţō	MD Baltimo:	re	Towson					1 ☐ Yes 2 ☒ No
		filed within 72 hours after death with the Maryland Hygiene. other then "natural", or Items 23e or 28e-f show ent. The Macked Examiner must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
		ath wi	ral	525 E. Seminary	Ave.		21 286			United 9	States
		itam Itam	Funeral		2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	erican Indian, ite, etc.
	36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1□ Yes 2□XNo	Specify:		Specify:	White
	21215-0036	72 hours aft natural', or neal Exami	Completed	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occup	pation during most of work id)		16b. Kind of Busines	s/industry
	21	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	auring most of work ad)	ang	Clothing	
W		iled w tygier her th		17. Father's Name (First, Middle, Last)		Seams	stress	40 11 11 11		Manufact	ure
77	and	d be f antal h	o Be	John Armetta				Sarah	e (First, Middle, Barr	Maiden Sumame)	
MAMI	Maryland	2 should be filed within and Mental Hygiene. is marked other then aumatic event, Inc. M.	우	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailir	g Address (Street			r, City or Town, State,	Zin Code)
		5 # 2 # Z		Ray Giudice/son			E. Semin		_	n, Marvland	
W	ore,	of Hea of Hea fitem r othe		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Re	20i	b. Place of Dispo	sition (Name of natory or other pla	(ce)	Date	20c. Location - City o	
2	Ĕ	ment of I		`4 Donation 5 Other (Specify)	5	t. Josep	h Cemete	ery 03/3	31/2004	Perry Ha	11, MD.
SWIDICE,	Baltimore,	permit. Pages Department of the Important: If Ite any injury or of once.		21. Signature of Funeral Service Livense	ne O		. Name and Addre	ΠL			Home, Inc.
17	100	DE GRAN		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the d	eath. Do not ent	050 York	Road Tou	or respiratory arr	ryland 21	204 Approximate
		Physician		Immediate Cause (Final					or respiratory are	001,	Interval Between Onset and Death
		/Medical		disease or condition resulting in death)	Due to (or as a cons		enesis	•			
D		Examiner		Sequentially list conditions	athoro	scletos	is				
0		p ii	iner	Sequentially list conditions, if any, leading to annuediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	raquence of):					
M	_	xecute and Il-tran	Examiner	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):					
2	760,	ate be executed hysicien and he burial-transit	cal E		200 10 (01 20 2 0011	754357765 G17.					
0)	9	leath certificate t attending physic I for use as the b		d.							
Z.	Вох	h cert endin	an/M	230. was decedent pregnant	3c. If yes, outcome of pred 1 Live birth 2 □ F		Ectopic pregnancy			23d. Date of de	livery
5	О. В	e deal the att	sicia	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4☐ Pregnant at time of		Other (specify)	y		Month	Day Year
+	٦	The law requires that the death certifica tie has been signed by the attending ph vage 2 should be detached for use as th	by Physician/Med	Part II. Other significant conditions conf		reculting in the un	daching cause an	von in Cont I	220 Did to		a the second death 0
4	Records,	w requires t been signe should be	d by	3	in out in grant of the control of th	rosannig ar trio tr	derlying cause giv	on mr Faiti.		oaccouse contribute t es 2™No 3□P	robably 4 DUnknown
5	S	w req	Completed						24a. Was a		
7		The lay	dwo						autops	y prior to ned? death?	utopsy findings available completion of cause of
22	ital		0	25. Was case referred to medical				26. Place of Death	1 Yes 2		2 □ No
2	>	S S	To B	examiner? 1 Tyes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatien	3□ DOA Oth			ince 6 □Other (Spe	cify)
(1)	n of	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	28c. Injun Wor			w injury occurred	
3	isio	ten Jeat tor: the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OR. Blace of Injury. A			Yes 2 □ No			
01	Division	2 2 2 2	Certification;	4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, tarm, stre	et, factory, office		28t. Location (St. City or Town	reet and Number or R n. State)	ural Route Number,
bate		To the Hospital or All within 24 hours after of the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physi	ician: To the best of my k	nowledge, death	occurred at the tin	me, date and place,	and due to the ca	ause(s) and manner as	s stated.
()		he Ho in 24 he Fu pletel	Medicai	(Check only 2 Medical Examin	er: On the basis of exam and manner stated.	ination and/or inv	estigation, in my o	pinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
		vith To t	Σ	29b. Signature and title of certifier			29c. Licens	e number	29	9d. Date signed (Mont	h, Day, Year)
				an more		0.0	.,	646		March	7 200 Y
`		5		30. Name and address of person who con	npleted cause of death (I		COMPANY STREET	Porke	11	O was	
		Sta	te	31. Date filed (Month, Day, Year)	32. Registrat/s Sig		1600, 50	70-	140 - N.	10 212	27
	A.	Registr		MAR 3 U 2004	ESTIGNA AS						

		•	For State Registrar		State of	Marylar		artmen				lental Hy	/giene Reg. No.	20	104	097	5
	Physici		1. Decedent's Name Silas Nor									2. Date of De Month March 2	Day	004	Year	3. Time of Deal	
j	/Medic Examin		4a. Facility Name (If			oer)		4b. City,	Town, or	Location (of Death				of Death	l.,	
			9912 Marr	iottsvil	le Road	Apt. 2	203			town				ltim	ore_		
	Funeral Director		5. Social Security No. 212-20-84		Sex 7 1SXM 2□F	Age (In yrs. 91	last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, Di Dec. 2	$\overset{\text{rth}}{1}$, $\overset{\text{rth}}{1}$	12	Coun	ace (State or For try) Land	reign
	w w	}	Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation					-		11	Od. Inside City Lin	mits
	Marylis f eho	jo	MD	Baltimo	re		Randal:		n							1 ⊠Yes 2 □	
	r 28a	rec	10e. Street and Num	ber				10f. Zip	Code				10g. Citiz	en of W	hat Coun	try?	
	th with	ai D	9912 Marr	iottsvil	le Road,	Apt.	203	2	1133	}			U.	S.A	•		
39	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23s or 28a-f ehow other traumatic avent, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Marrie 3 Widowed	21	12. Was Deced Armed Ford 1 Tyes 2 If Yes, Give Year or Dat	es? [XNo	If Yes, specify Cuba			spanic Ori n, Mexicar Specify:		ecify Yes or N Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: White			
ŏ	2 hou	ted	/Sanai	15. Decedent's E			16a. Dece	dent's Usua	I Occupa	ation	et of work	ina	16b. Kin	d of Bus	siness/Ind	ustry	
21215-0036	thin 7	Completed by	Elementary/Secon	fy only highest grandary (0-12)	College (1-4	or 5+)		kind of wor bo NOT us keepe)	N OF WORK	ii ig	Comme	roi	a1 C	rodit	
S	filed with Hygiene other tha		12	Cimt Middle Lee	3_		BOOK	pc	<u>. </u>	10 Moth	ora Nome	e (First, Middle				-EUTC	en ath
Maryland	ould be fi Mental H larked ot atic avar	To Be	17. Father's Name (Silas Fl									Alveit			7)		
ary	and Men le marke aumatic		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Run	al Route Numb	er, City or	Town, S	State, Zip	Code)	
	1 and 2 Health a lem 27 le		Richard N	. Gardne	r/Son	,				Road	_	kesvil					
ore	of Hi		20a. Method of Disp		Removal from SI		Place of Dispo	matory or of	ther plac	e)		Date OO/			City or To		
Baltimore,	nit. Pages artment of I ortant: If it injury or o e.		` 4 ☐ Donation ²	5 ☐ Other (Speci	fy)	Met	ro Crem				/30/2		Caton				
Bal	permit. Page Department o Important: If any injury or once.	7 1	21. Signature of Fur	Nelsor	3um	brun	60		<u>kes</u>	ville	Roa	l. Zumbi d, Elde	ersbu			1784	
			Immediate Cause (t failure. List only Final	one cause on ea	ch line.	î		_		n 1	or respiratory a				Approximate Interval Between Onset and Death	ר
1	Pnysician /Medical		disease or condition resulting in death)	•	a	as a consec		Prid	o Ca	nana	A 60	مهددريس			-	Jean Jean	,
н	Examiner		Sequentially list con	ditions	b				0.0						3		
0,	s be executed sician and surial-transit	Examiner	any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):														
68760	ficate be physici s the bu	edical			d									-			
.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								23d. Date of delivery Month Day					•	
S, P	res that igned b	by Pt	Part II. Other signifi	T _a	contributing to dea	th but not res	sulting in the u	nderlying ca	ause give	en in Part I				1		e cause of death?	
ord	w require been si should b	ted	1/0 Ceton	any an ler	y ogran	73 1711	nguy	19	12			1 🗆	Yes 2	No :	3 🔲 Proba	ıbly 4 ∐Unkno	own
Vital Records,	sician: The law r certificate has be rector, page 2 sh	Completed	Parkma	ions l	Disease							24a. Was auto perfe 1 \(\text{Yes}		pr de	rior to comeath?	sy findings availa ipletion of cause 2 No	able of
Vita	ician: Th certificate rector, pag	Be	25. Was case referr examiner?	ed to medical	Hospital:				Oth			(Check only					
of	hy this al di	<u>۲</u>	Yes 2☐ 1 27. Manner of Death		I L. In		ER/Outpatier 28b. Time o	-		4 NU		me 5 Aes 28d. Describe)	
	ding After fune	tion	128Natural	5 Pending investigation	28a. Date of (Month,	Day Year)	Injury	M	8c. Injury Work	k? Yes 2 ☐		Ebd. Describe	now injury	occurre	·u		
Division	or Atten fer deat irector: n by the	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place o	f Injury - At h J, etc. (Speci	lome, farm, str fy)	-					(Street and wn, State)	Numbe	r or Rural	Route Number,	
×	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)		hysician: To the b miner: On the bas and manne	is of examina											
	To the within To the comple	Me	29b. Signature and	title of certifier	\		<u> </u>	29c		number	3		29d. Date	_	-	7.	
			PY, Chi	obser Ot	Lowerest	, M.	D.		DO 1	632			Man	ch	30,	200 4	
	')		30. Name and address.	D'O MA	MONONO	, M.D	, 20	Print)	GNA	ALK	AVE.	BAL	-TO. 7	M	D 2	-1222	
	Sta Registr		31. Date filed (Mont	h, Day, Year) 0 2004	Jens 1	gistrar's Signa	ature A	borks	7								

		1 = For State Ragistrar	State of Maryland	Certific	cate of	Dodin	ne.	ig. No.	
Discontinuit		1. Decedent's Name (First, Middle, Las	t)				Date of Deatl Month	h Day Year	3. Time of Death
		Charles F. Gress,	Sr.				Mar.	27 2000	<i>I</i>
	6 4	4a. Facility Name (If not institution, give	street and number)			or Location of Death		4c. County of Dea	ath
7		ST-AGINE'S HEALTH			ALTIN		O Data of Birth	N/A	- Charles (Charles)
8 .		5. Social Security Number 6. Se	ax 7. Age (In yrs. las XM 2□F 86		nths Days	Hours Min.	8. Date of Birth (Month, Day,)ec. 20,	Year) 9. Bi	rthplace (State or Foreign
ector		214-01-8361 Usual Residence of Decedent	00			1 1	Jec. 20,	1917 M	aryland
=		10a. State 10b. County	10c. City,	Town or Location	1				10d. Inside City Limits
De la	ţ	MD Baltimor	e	Ва	1timor	·e			1 ☐ Yes and No
	Director	10e. Street and Number			f. Zip Code		10	g. Citizen of What C	Country?
	aD	6105 Wheatland Ro	ad			21228	U	nited Sta	tes
	Funeral	11, Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was D	Decedent of H	Hispanic Origin? (Spec an, Mexican, Puerto R	city Yes or No-	14. Race - Am Black, Wh	
		1 ☐ Never Married 2 Married	1 NYes 2 No 5-25	-45	es 2 💢 No		, ,	Specify:	White
	d by	3 Widowed 4 Divorced	Year or Dates: 7-13-4	6			i		
	Completed	15. Decedent's Ed (Specify only highest grad		16a. Decedent's (Give kind o	Usual Occup of work done OT use retire	during most of workin	a l	16b. Kind of Business	•
Ital or Attending Physician: The law requires that the death certificate be executed is steer death. Italian Physician: The law requires that the death of death and Mental Hygiene. Italian Physician and Seen signed by the attending physician and Seen in the Medical Earth and Mental Hygiene. Importent: It itam 27 is marked other than "natural, or Itams 23 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked other than "natural, or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is marked or Itams 24 is	E D	Elementary/Secondary (0-12)		Baltimore City Fire Department					
	e Co	17. Father's Name (First, Middle, Last)			Captai	18. Mother's Name		-	tment
	0	J. Howard Gress					abeth M		
	ဥ	19a. Informant's Name/Relationship (7	voe. Print)	19b. Mailing Add	dress (Street	and Number or Rural			Zip Code)
		Janice Gettier, D							
		20a. Method of Disposition	20b. Plac	e of Disposition	(Name of			20c. Location - City o	r Town, State
		1 ☐ Burial 2 X Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	etery, crematory		1	0 200	D-1-4	- W.MD
		2 . Signature if Funeral Service Licent				, Inc. 3-2			
DOC		(some man)	DAM HAI			ess of Facility Ambr our Spring			
	\dashv	23a. Part1. Enter the disease, or comp	olications that caused the death.						Approximate
		shock, or heart failure. List only of Immediate Cause (Final							Interval Between Onset and Death
		disease or condition resulting in death)	a. PNEUMON Due to (or as a consequer						10 days.
r			546 to (01 45 4 5011504501	100 017.					
A.	e	Sequentially list conditions, lary leading to immediate cause. Enter Underlying	b. Due to or as a consequer	nce of):					
	Examiner	Cause (Disease or injury that initiated events	C						
		resulting in death) Last	Due to (or as a consequer	nce of):					
	cal		d						
	Jed	IS SELVALS.							454
	an/	23b. was decedent pregnant	23c. If yes, outcome of pregnanc 1 ☐ Live birth 2 ☐ Fetal de		pic pregnancy	v		23d. Date of de	
	sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of deat 9☐Unknown	th 5 🗆 Othe	er (specify) _			Month	Day Year
	Phy	9 Unknown				1.0.11	00 - Did tob		
	by	Part II. Other significant conditions on HYPERTENSION	ontributing to death but not resulti	ng in the underly	ring cause giv	ven in Part I.			to the cause of death? Probably 4 🗷 Unknown
	ted						1 19		
	ompleted	CORUNARY ARTER	Y DISEASE.				24a. Was an autopsy	prior to	utopsy findings available completion of cause of
1	Con						perform 1 Yes 2		s 2 🗆 No
. 1	Be	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	9)	
	P.	TES ZENO	Hospital: 1 ☑ Inpatient 2 ☐ EF			4 Nursing Hom		nce 6 Other (Spe	ecify)
	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Injury	28c. Injur Wor	rk?	8d. Describe ho	w injury occurred	
	cat	2 Accident investigation 3 Suicide 6 Could not be		M		Yes 2 □No	Of Lanation /Car		
	E	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, fa	actory, office	21	City or Town,	eet and Number or F , State)	lurai Roule Number,
		00 0 di 1 di 1 di 1 di 1 di 1 di 1 di 1	* * * * * * * * * * * * * * * * * * *	-4 44					
		29a. Certifier 1 ☑ Certifying Phy (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowle liner: On the basis of examination	edge, death occu n and/or investig	arred at the tile ation, in my o	me, date and place, ar opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	is stated. e to the cause(s)
	ical		and manner stated.		29c. Licens	se number	29	d. Date signed (Mon	th Day Year)
	Medical								
	Medical	29b. Signature and title of certifier	- M-D		P	-17590		03-27-	2004.
	Medical	29b. Signature and title of certifier	M-D			-17598		03-27-	2004,
completely fill	Medical	29b. Signature and title of certifier	completed cause of death (Item 2				,		

			Amend Item 1 per Dr., C83P, C83P, Many and / Department of Health and Mo Certificate of Death	Reg. I	/ 1111	
	Physici		RICAL HEZEVIAH GREEN	/	Pay Year	
	/Medic		4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Loc	mayech death	4c. County of De	
\forall	LXdillin		2807 F. BIDDLE STREET BACTION			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month, Dev Yea	927 V	irthplece (State or Foreign Sougtry) [KGI N I A
	/land		10a. Stete 10b. County 10c. City Town or Location			10d. Inside Pity Limits
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21215-0020	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show ha Medical Examiner must be notified at	Completed by Fune	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armer Forces? 1 □ Wes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Specify Cydan, Mexican, Puerto R) 14. Was Decedent of Hispenic Origin? (Specify Specif	ify Yes or No- lican, etc.)	14. Race - Am Black, Wh Specify:	
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þ	be filed with tal Hygiene. d other than event, the	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maide	•	
ylar	should be filed and Mental Hygi marked other imatic event,	To	CHESTER R. GREEN CARV	E PO	WELL	
, Maryland	end 2 sho salth end n 27 is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel 2807 E. BIDDLE.			Zip Code) MD 2/213
Baltimore,	ges 1 t of He if Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State		Location - City o	
흩	t. Pertrant	4	4 Donation 5 Other (Specify) GREENTOWN FAMILY CEMETERY 4	1-1-04 LAU	URENCES	VILLE, VA
Bal	Demi					
			23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or		E, MAL	JUAND 21212
A. S. S. S. S. S. S. S. S. S. S. S. S. S.	Physician		shock, or heart failure. List only one cause on each line.	respiratory arrest,		Approximate Interval Between Onset and Death
-	/Medical		Immediate Cause (Final disease or condition resulting in death) e. CONGESTIVE HEART FAILURE			VEARS
	Examiner		resulting in death) e. CONSTANT THEORY Due to (or as a consequence of):			yerks
	be sit	ine	a b.			i
	be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
68760,	S Si		Cause (Disease or injury			
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Box	attending for use	ary	d			
	e dea the at hed fo	3ic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacc	o use contribut	e to the cause of death?
P.0	hat the	by Physician/N		1 🗆 Yes	2□ No 3□P	Probably 4 Unknown
Records,	v requires that the death cer been signed by the attendin should be deteched for use	d b		24a. Was an auto	oney 24h	Were autopsy findings
9	w req	Completed		performed?	,psy	available prior to completion of cause
æ	The lew sete has b page 2 s	E		1 ☐ Yes 2	2₽No	of death?
of Vital	certificate rector, pag		25. Was case referred to medical 26. Place of Death (.7110	163 25140
) \	Physician: this certific	9	Hospital:	5 ☐ Residence	6 Other (Spe	ecity) HOSDice
ū	onera		1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work?	d. Describe how inju	ury occurred	
Division	Attending r death.	Cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined determined 28e. Place of Injury : At home, farm, street, factory, office 28	f. Location (Street a	and Alexanders on E	hand Barrier Marchan
Θ	offer Direct	Certification:	4 Homicide determined building, etc. (Specify)	City or Town, Star		urai noute Number,
	To the Hospital or Attending Phys within 24 hours effer death. To the Funeral Director: After this completely filled in by the funeral di		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and and manner stated.	d due to the cause(s at the time, date an	s) and manner a nd place, and du	s stated. e to the cause(s)
	withir To th comp		29b. Signature and Little of certifier 29c. License number	29d. Da	ate signed (Mon	th, Day, Year)
	./		10561	m	ARCh 24	2004
	5	3	29b. Signature and attree of certifier P16561 30. Name and at these of person who completed cause of deeth (Item 23a) (Type, Print) MADIA CINA MD Registrar's Signature Registrar's Signature	111 2		/
6	State	. 3	MADI & CINA MD IN. GREEN & STREET BA	et. MURE, 1	ND 212	201
	Registra	e ,	MUTIN O COULD SERVE STORES			

227-20-747

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) GOETZINGER Physician Month Year THOMAS 10:15P M MARCH 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Medical Examiner OF MARYLAND UNIVERSITY CONTER BALTIMORE n/a | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | April 21, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1 ☐ M 2 ☐ F 1948 Maryland 55 Director 217-50-3706 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location worde ! i Hygiene. other than "natural; or Items 23a or 28a-f ehov vent, the Medical Examiner must be notified at Harford Bel Air 1 ☐ Yes 2 No Md. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21014 731 Fairwind Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after ☐Yes 2XNo 1 ☐ Never Married 2 Married white Maryland 21215-0036 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry city government Elementary/Secondary (0-12) College (1-4or 5+) (Baltimore) director of finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Department of Health and Menial Hy Important: if Item 27 is marked oth any injury or other traumatic even once. Pages 1 and 2 should be Patricia Sheridan John Goetzinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 731 Fairwind Drive, Bel Air, Md. 21014 Elizabeth Goetzinger/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/31/2004 Bayview Crematory Baltimore, Md. `4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 I ive birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a Ö م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ HEART FAILURE 1 🗌 Yes 2 (L) No 3 Probably 4 □Unknown been sig Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has e 2 s s certificate has lirector, page 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 1 to atient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification; After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: , 6 ☐ Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Within 24 hours are To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 26 2004 P17657 MO 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GIRENE STREET BALTIMORE, MARYLAND 21201 Rebecca MANNO, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2004 Registrar

DHMH 17 Rev 1/2001

Funeral

Director

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permit. Page Department of Important: If any injury or

Physician /Medical

Examiner

12 should be finance and Mental F

within 72 hours after

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** MARCH 2004 1:14P. James В. Guinessey /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE NORTHWEST HOSPITAL CENTER RANDALLSTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₩ 2□ F 116-50-3286 46 3, 1958 NY Usuel Residence of Decedent 10c. City, Town or Location 10a. State 10d. fnside City Limits 1 ☐ Yes 2 ☐ No Director Carrol1 Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2103 Spencer Lane 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: à 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Financial Representative T. Rowe Price 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Joseph Guinessey Kathleen L. Donlon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 Spencer Lane, Finksburg, MD 21048 Nell Guinessey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Kremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 3/30/04 Carroll Cremation Hampstead, MD 21. Signal re #Funeraf Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Buy Eline FuneralHome Reisterstown, MD 21136 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf disease or condition resulting in death) Atherosdentic cardiovascular Due to (or as a consequence of): Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\subseteq \text{No.} \) 1 X Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Examiner law requires that the death certificate be executed signed by the attending physicien and be detached for use as the burial-transit Box 68760 Physician/Medical P.O. 1 Division of Vital Records, þ certificate has been si rector, page 2 should Completed After this Certification:

s after death. Hospital or within 24 hours a To the Funeral D the t

O

State Registrar

Medical

6 Could not be determined

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

O.C.M.E.

MARCH 26,2004

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

3 🗍 Suicide

29a. Certifier

4 - Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar's Signature

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year Mary Emma Gerstad March 28 2004 3:35 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Essex Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 □ M 2 ♥ F Yrs. 216-20-6505 78 July 23 1925 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1109 Washington Irving Lane 21220 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2☐ Married 1 ☐ Yes 2 ☐ XIo If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: white 3 ☐ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Chemical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Nelson G. Gerstad Mary Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

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10a. State

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

Department of Health and Mental Hygiene. It mouts after dearn with the Marylar Important: If item 27 is marked other than "natural, or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at once.

anding physician and use as the burial-transit

certificate be executed

completely filled in by the funeral director, page 2 should be detached for	Division of Vital Records, P.O. B		Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the deat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atternation of the Funeral director, page 2 should be detached for	20	Stat
To the Funeral Director: After this certificate has been signed by the a		Division of Vital Records, P.O. F	To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.	1	

	Charles Siegman/frier	d 1109 Washington Irving Lane, Balto.,	MD 21220
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City	or Town, State
		Cedar Hill Cemetery 4/3/04 Brooklyn	Park, MD
	21. Signature of Funeral Service Licensee	Lemmon Funeral Home of Dulaney 10 W. Padonia Rd., Timonium, MD	Valley, Inc. 21093
	23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line.	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a.	Protectile Cardiac Arthythmias	Few his.
liner	- b f	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	in Known
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or as a consequence of):	
dicai	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
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by Phys	Huber tension	Town C Conding by Solution of the underlying cause given in Part I. 23b. Did tobacco usa contribution of the underlying cause given in Part I. 23b. Did tobacco usa contribution of the underlying cause given in Part I.	
Be Completed by	Anomia, Adu	a ced Algheiner's Demorte 24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death?
Comp		1□ Yes 2□No	1 □ Yes 2 No
Be	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
ဥ	1 ☐ Yes 2 ☐ No Hospital:	☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Sp	ecify)
Medical Certification:	Natural 5 ☐ Pending (a) 2 ☐ Accident investigation	te of Injury 28b. Time of Injury 28c. Injury at Work? M 28c. Injury at Work? 1 \[\text{Yes} 2 \] No	
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. F	ace of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Indiang, etc. (Specify) 28f. Location (Street and Number or Indiang, etc. (Specify)	Rural Route Number,
edical	Madical Examiner: On the	the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and duanner stated.	as stated. ue to the cause(s)
Ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Mor D - 3 8 7 5 4 03 - 29	
	30. Name and address of person who completed MALIKA WASER	ause of death (Item 23a) (Type, Print) 1. FOG. EASTERN BLVD - MD -	21221.

32. Registrar's Signature

Registrar

31. Date filed (Month, Day, Year)

MAR 3 0 2004

Textination of the property for a marketonic pre-stored and cameral property for a marketonic property for a marketonic property for a marketonic property for a marketonic property for a marketonic property for a marketonic property	Physic		1 - State Registrar AMEND ITEM #206 1. Decedent's Name (First, Middle, Last) Charles W.					2. Date of De Month	Day	Year 2004	3. Time of Death 2;05 P.M.
Printed Prin			4a. Fecility Name (If not institution, give s	treet and number)				THE STATE OF THE S	4c. Count	y of Deeth	
Source and source of the part			Social Security Number 6. Sex	7. Age (in yrs.	Mo			8. Date of Bir May	** 1942	9. Birthp Cour	olece (State or Foreign NA)
The state of the	Aaryland f show	or	10a. State 10b. County		ity, Town or Location		en Burnie			1	
The state of the	with the h s or 28s-		10e. Street and Number	under	10				-		ntry?
17. Famer's Name (First, Middle, Last) George Hampton Near Replace Hampton Near Replace Hampton Near Replace N	5 £ 3	by Funera	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give			tispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. Ra Bla	ce - Americ ick, White,	etc.
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Curt C. Bradshaw II (step-son) 4 Hinhland Road, Glan Burnie, MD 21050 20a Method of Deposition (Promission City of Town, State Part 1	be fife oth	Be	17. Father's Name (First, Middle, Last)	ampton			18. Mother's Name			me)	
A Baltimore, Maryland Comparison Compar	and 2 sho lealth and I may list me		Curt C. Bradshaw	[[(step-son) 4 High	land R	Road, Glan	Burnie	e, MD 21	060	
Physician Middleal Examiner 23a Part State the display of completable that called the death. Do not enter the mode of dying, such as cardac or respiratory areast. Interval Baween Conset and Death (Present Present	timore Pages 1 tment of H tent: If ite		XX Burial 2 X6remation 3 □R 4 □ Donation 5 □ Other (Specify)	emoval from State	tro Crema	tory I	^{ce)} Marc nc20	h 29 04 9/3	Baltimo	re, M	1ary1and
Physician Middical Examiner Timediate Cause (Final Indication (Final Indication (Final Indication)) Timediate (Final Indication) Timediate (Final Indicat	Ball permit Depar Impor		1 July	7	311	1 Mour	ntain Road	, Pasac	dena, MD		22
Duilding, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	/Medical Examiner	cal	disease or condition resulting in death)	prenn	yunica sti:	tal ne pr	Canu Canu Ummy	Rise	900		Onset and Death
During the control of	.O. Box the death certily the attending	nysician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	el death 3 Ecto		у				•
Duilding, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	rds, P		Part II. Other significant conditions cor	stributing to death but not re	sulting in the underly	ying cause giv	ven in Part I.				
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The straight of the straight o	of Vit	To B	examiner? 1 Yes 2 No	1 Vinpatient 2L		_ DUA	ner: 4 Nursing Ho	me 5 Resi	dence 6 Oti		γ)
The state of the s	ision trending death. stor: After	cation	1 Natural 5 ☐ Pending 2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		Injury N	1 10	Yes 2 No				J Route Number
	Div		4 Northclas	ı			1	City or To	wn, State)		
	the Hos hin 24 h the Fun mpletely	Medica	(Check only one) 2 Medical Exami	ner: On the basis of examin	ation and/or investig	ation, in my o	ppinion, death occurr	ed at the time,	date and place,	and due to	the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (Mb) (h. Oker unin 30) (Hyper Cular Summe MD 2106).	T wit	_	A A	è	La.	D 44	2677				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 14:54 Ntho March 22 Y005 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Y Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Days 213-60-7350 Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? ō 5 1 and 2 should be filed within 72 hours after death wi Health and Mental Hygiene. 9m 27 Is markad other than "natural", or Itams 23a o by Funerai Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: B 14 e K 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ElectriciAN 17. Father's Name (First, Middle, Last) even Department of Health Important: If item 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State mtcarmel Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility was 12/Chay. S Jr. 2007 Eastern Ave any 13 alto MD 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pheumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending physician Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, pe Cerebravescular 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? Division of Vital 1 Yes To tha Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient ဂ္ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albrecht

31. Date filed (Month, Day, Year)

2004

TII

32. Registrar's Signature

			1 - For State Registrar	State of Ma	-	epartmer Certificat			d Mental Hy	Reg. No. 2	004	09759
	Physici /Medic		Decedent's Name (First, Midd Emma	Louise Healy					2. Date of Domestin	Day 10 26, 20	OO4	3. Time of Death
22	Examir		4a. Facility Name (If not institution Milford Manor			Pi	kesvi		eath	4c. Count	y of Death Baltim	
	Funeral Director		5. Social Security Number 085–32–2089	6. Sex 7. Ag	e (In yrs. last birth 87 Y	Months	1 Year Days	Hours M	in. 8. Date of Bi (Month, D 	T, 1916	9. Birthpl Count Rhode	ace (State or Foreign try) e Island
	show	7	Usual Residence of Decedent 10a. State 10b. County Md. Balt	imore	10c. City, Town	or Location	lls				10	0d. Inside City Limits
	death with the Maryland ma 23a or 28a-f show rmust be notified at	Director	10e. Street and Number	watha Court		10f. Zip				10g. Citizen of		iry?
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. By any injury or other traumatic event, the Medical Examinar must be notified at once.	y Funeral	11. Marital Status 1 (其Never Married 2 ☐ Mar	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀!	Ever in U.S.		dent of His		(Specify Yes or Note to Rican, etc.)		ce - America ck, White, e	
Z 13-00,	thin 72 hours e. an "natural", Medical Ex	Completed by		Year or Dates: nt's Education est grade completed) College (1-4or 5	(i+)	Decedent's Usu 'Give kind of wo life. DO NOT u	rk done du se retired)	ring most of t	working	16b. Kind of B	lusiness/Ind	lustry
Jana Zi	I be filed wil ntat Hygien ed other th	Be	10 17. Father's Name (First, Middle,	, Last)	å	Staff A		8. Mother's N	Name (First, Middle			ntal Hygien
Maryi	nd 2 should alth and Mer 27 is mark r traumatic	To	Arthur F. 19a. Informant's Name/Relations Myra Saltzman	ship (Type, Print)				nd Number or	Rural Route Numb timore, 1			Code)
altimore,	Pages 1 a ment of Hei tant: If item jury or othe	100	20a. Method of Disposition 1 Durial 2 Cremation 4 Donation 5 Other (5	Specify)	cemetery	Disposition (Nai crematory or o	ther place)		Mar. 29	20c. Location 2004 T	-	
Da	permit Depart Import any in		21. Signature Poneral Service	black		11002	rdt F Reis	uneral tersto	Chapel, wn Rd.,	wings M	ills.	Md. 21117
	Inysician /Medical Examiner		23a. Part1. Enter the disease, o shock, or near failure. List Immediate Cause (Final disease or condition resulting in death)	a	a consequence of	retus:	e of sving.	Bulg	dist Ca	rrest,	111	Approximate Interval Between Onset and Death
	icate be executed physician and s the burial-transit	I Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of							
O. BOX 66/60,	w requires that the death certificate to been signed by the attending physicatould be detached for use as the to	hysician/Medical	IF FEMALE: 23b. Was decedent pregpant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	2 Fetal death	3 □Ectopic pr 5 □ Other (sp					ite of deliver	y Day Year
cords, r.	quires that I an signed by uld be deta	by P	Part II. Other significant conditi	ons contributing to death b	ut not resulting in	the underlying o	ause given	in Part I.		obacco use con: Yes 2 No		e cause of death?
ח שבני	The law re cate has bee page 2 sho	Completed							24a. Was auto perfo 1 ☐ Yes	rmed?	death?	sy findings available of cause of
ISIOII OI VIIG	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. Within 24 hours after death. To the Furnatal Director: After this certificate has been signed by the attending completely filled in by the funeral director. page 2 should be detached for use a	Certification; To Be	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da)	ry 28b. Ti	ury M	8c. Injury a Work?	Nursing			red	
2	ospital or A hours after uneral Dire ly filled in b		4 Homicide determ	building, etc	c. (Specify) of my knowledge,	death occurred	at the time	, date and pla	City or To	wn, State) cause(s) and ma	anner as sta	ited.
	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical one) 29b. Signature and title of certifie	Examiner: On the basis of and manner sta	examination and	290	. License r	number		29d. Date signe	d (Month, D	Pey, Year)
	5		30. Name and address of person	who completed cause of d		ype, Print)	38 1	150	re To	51	1 410	# 70
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	mun ar's Signature	and a	· U (rece	re 1º			. 300

			For State Registrar	State of N	Marylan		artment o			Mental Hy	/gien Reg. N	2001	+ 09760
	Physici		1. Decedent's Name (First, Middle	e, Last)	s Kun		- · · · - · · ·			2. Date of D Month	Di	y Year 7 7064	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution	n, give street and number	er)	<u> </u>	4b. City, To	wn, or Loc	cation of De	ath	40	. County of Dea	ith
			5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Y	ear If	Under 24 Hi	IS. 8. Date of B		I/A	thplace (State or Foreign
	Funeral Director		217-32-9718	1∰M 2□F	73	Yrs.			lours Mi		$\frac{19}{2}$	30 Mar	yland
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	ocation						10d. Inside City Limits
	ith the Marylar or 28a-f show	ector	Maryland Anne	Arundel	Arno	old							1 ☐ Yes 2X No
	with th	by Funeral Director	10e. Street and Number 738 Matchpoi:	nt Drive			10f. Zip Co				_	itizen of What Co	ountry?
	after death w	nera	11. Marital Status	12. Was Decede Armed Force	s?	S. 13.			nic Origin? (Mexican, Pue	(Specify Yes or Narto Rican, etc.)	USA °-	14. Race - Ame Black, Whit	
980	filed within 72 hours after death with the Maryland Hygiene. kther than "naturel", or Items 23e or 28a-f show ther than "naturel", or Items 12e Indiffical at ont, the Medical Exer it wermust be Indiffical at	by Ft	Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Voc Civo		ł	1 ☐ Yes 2 [∑		pecify:			Specify:	White
21215-0036	n 72 ho	Completed	15. Deceden (Specify only highes	t's Education st grade completed)		16a. Dece	dent's Usual C kind of work of DO NOT use r	ccupation	n ng most of w	rorking	16b. F	Kind of Business	/Industry
212	filed withir Hygiene. other than ent, I'LE M	фшо	Elementary/Secondary (0-12)	College (1-4d	or 5+)		L Emplo				U.S	. Post	Office
	d a b	a	17. Father's Name (First, Middle,	Last)						ame (First, Middle	e, Maidei	n Sumame)	
Maryland	should I and Meni Is marke	ဥ	UNK . 19a. Informant's Name/Relations					treet and i		Rural Route Numb	per, City	or Town, State, .	Zip Code)
	1 and 2 Health a tem 27 is		Edmund Thomas (20a. Method of Disposition	Ogle, Jr./F			Matchpo Seition (Marga)	ed color	Drive	Arno		MD 210	
mor	Pages nent of h int: If ite iry or of	H	1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S)		(Le)		sition (Name of matory or other ematory		. 3_4			1timore	
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau <u>2006</u> .		21. Signature of Funeral Service	Licensee	, , , ,	22	Name and A	ddress of	f Facility				
	402 6 0		23a. Párti. Enter the disease, or	complications that caus	sed the deeth							re, MD	21228 Approximate
	Physician		shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	s /S								Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):							
	po tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	uence of):							
,	ate be executed thysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	as a consequ	uence of):							
8760,	ate be physicia the bur			d.							_		
Box 6	teath certifica attending ph d for use as th	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom						- C		23d. Date of del	livery
O. B.	law requires that the death certificate be executed as been signed by the attending physician and 's should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant 9□Unknown	at time of de		Ectopic pregr Other (specif					Month	Day Year
0	res that the de igned by the a be detached to	by Ph	Part II. Other significant condition	ons contributing to death	n but not rest	ulting in the u	nderlying caus	e given in	ı Part I.	23e. Did	tobacco	use contribute to	the cause of death?
Records,	w require bean sig should b									1 🗆	Yes 2	□No 3□Pr	obably 4 DUnknown
Rec	The law ate has b page 2 s	Completed									psy ormed?	prior to death?	atopsy findings available completion of cause of
Vital	Physicien: The lithis certificate har all director, page	Be	25. Was case referred to medical examiner?		/				. Place of De	1 ☐ Yes eath (Check only	2□Na one)	1 □ Yes	2 <u>[]</u> NG
of	g Physi er this c eral dir	n: To	1 Yes 2 No	Hospital: 1 Dinpa	njury	ER/Outpatier 28b. Time of		Other: 4 Injury at Work?	4 🔲 Nursing	Home 5 ☐ Res 28d. Describe			city)
Division	Attending Fr death. sctor: After by the funer	catio	1 D atural 5 Pendin 2 Accident investig 3 Suicide 6 Could	gation	Day Year)	Injury	М	1 ☐ Yes	2 □ No				
Divi	al or Attence after death Director: d in by the	Certification:	4 Homicide determ	ined 286. Place of	Injury - At ho etc. (Specif)		eet, factory, of	fice		28f. Location (City or To			ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 / Crtifyin (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basis	s of examinat	wledge, death tion and/or in	n occurred at the	he time, d my opinio	date and place on, death occ	ce, and due to the curred at the time,	cause(s date an) and manner as d place, and due	stated. to the cause(s)
	To the within 2 To the Comple	Mec	29b. Signature and title of Certifier	and manner	stated.		29c. Li	cense nur	mber		29d. Da	te signed (Monti	h, Day, Year)
	./		Michael	a litela	en j	MO.	RE	ES C	200		11/1	rch 2	7, 2004
	b		30. Name and address of person	who completed cause o	of death (Item	23a) (Type,	Print)	quen	1310	el Bali	5 mo	re MI	7, 2004 D. 21239
	Sta Registr		31. Date filed Alegth Day Year	04 32. Regi	strar's Signa	ture	وع						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 State Registrar AMEND ITEM #6&11 PER INF G830 4/08/6 Pertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 7:15 A Romona D. Harris March 28 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville St. Martin's Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Months | Days Hours 74 217-26-9020 Jan. 31, 1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Harford Joppa MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U. S. A. 21085 415 Haverhill Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc.
White 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 Nidowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dolores Margarite Rebstock Henry William Fleischer 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, State, Zip Code) 415 Haverhill Rd. Joppa, MD. 21085 19a. Informant's Name/Relationship (Type, Print) Sandra Stilling, daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Glen Haven Memorial Park 04-01-04 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie, MD □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityAmbrose Funeral Home of Lansdowne 🏂 2719 Hammonds Ferry Rd., Lanasdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final STAPHYLOCOCCAL SEPSIS 3 WEEKS disease or condition resulting in death) Due to (or as a consequence of): 3 WEEK HBDOMINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ ADVANCED PARKINSONS DISEASE WITH DEMENTIA 1 TYPES 2 NO 3 Probably 4 SOUNKNOWN Be Completed ESSENTIAL HYPERTENSION PNEUMONIA. 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No SPLENECTOMY. STATUS POST 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Kanalle Zan March, 29, 2004. D18362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE. Suite 308. BALTO. MD21229 3455, WILKENS KOMAL K. DANGM.D. 31. Date filed (Mon AR 3ar) 2004 32. Pegistrar's Signature State

Registrar DHMH 17 Rev 1/2001

nours after death.

neral Director: A

To the Hospital within 24 hours a To the Funeral Completely filled

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

itled within 7 Hygiene. other than "n

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: if Item 27 is marked other that any injury or other traumatic event, that one.

Physician

/Medical

Examiner

use as the burial-transit

the attending physician

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 2004 09762 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year MARCH /Medical LOOL 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Deat AVENUE MORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Yrs. Director MARCH 6,192 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic event, if a Medical Examinar must be notified at 10d. Inside City Limits 1XYes 2 No Director MARYLAND 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE 6 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Completed by 'natural' Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 THGRADE WORKER MESTIC HomES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be I Department of Health and Mental I Important: If item 27 Is marked o ೭)ANIEL JOHNSON 11 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) AVE 100 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date Important: If it any injury or o once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses TR. FUNERAL HOME . FULTON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): Examiner physician and the burial-transit certificate be executed ERTEN Due to (of as a consequence of): Physician/Medical use as the attending Box IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 🗌 No 3 Probably 4 Unknown page 2 should Completed been MOK 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? res 2 No certificate of Vital 1 ☐ Yes tuneral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Alter Division or Attending 1 Natural 5 Pending death. thours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D the Hospital 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of entitier 29d. Date signed (Month, Day, Year, 29c. License number MARCH 25, 2004 30. Name and address of pers in the completed cause of death (Item 23a) (Type, Print) STREET, BALTIMORE, MD 21225 MATIDI 3001 SOUTH HANOVER FARZAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 1.

			1 - For State Registrar	State of Ma		Department of Certificate of			giene Z U U Reg. No.	14 09763
	Physici		Decedent's Name (First, Middle, Last)		23			2. Date of De Month	ath Day Ye	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	S _v	Hen.	4h City Town	or Location of Dea	March	4c. County of E	
	Examin	er		Jursing!	Center	Ranc	1 00-1-		Bac	chimore
	Funeral Director		5. Social Security Number 6. Sec 216-07-8272		93	hday) If Under 1 Yea Months Days	r If Under 24 Hrs	R Date of Bir	th y, Year) 25 1910 M	Birthplace (State or Foreign Country)
/land	A 1		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
в Мал	telling	ctor	MD Baltimo	re	Randa	allstown				1 ☐ Yes 2 XNo
vith th	or 28	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
leath v	ns 23 ₂	erai	4511 Robosson Rd	12. Was Decedent E	Ever in U.S.	211 13. Was Decedent of If Yes, specify Cu		Specify Yes or No	USA - 14. Race - A	American Indian,
IIIU Z I Z I J J J J J J J J J J J J J J J J	f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28e-f show other traumatic event, the Medical Examinational technitish at	Ď	1 Never Married 2 Married 3 Widowed 4 QOivorced	Amed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	If Yes, specify Cu		rto Rican, etc.)	Specify:	white, etc. white
72 h	natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted)</i>	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retir	e during most of wo	orking	16b. Kind of Busine	ess/industry
withir	iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5		ecretary	80)		Football	
e filed	Mental Hygiene arked other tha atic event, the	Be C	17. Father's Name (First, Middle, Last)	,		30.03			, Maiden Sumame)	
E P	Menti varkec	인	William Schwarzenk	-	401	Malife Address (Char		Eirely	- Church Town Shot	to Tip Code)
	Ith and 27 fs mu trauma		19a. Informant's Name/Relationship (T) William C. Henry/s			. Mailing Address (Stree 265 Ulmerto			-	L 33771-4138
s 1 and	of Health item 27 r other tra		20a. Method of Disposition		20b. Place of cemeter	Disposition (Name of y, crematory or other pl	lace)	Date	20c. Location - City	or Town, State
Pages	ment c ant: ff ury or		1 XBurial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		Lakevi	ew Cemete	ry 3/2	9/04	Sykesvill	
pall.	Department of H Important: If ite any injury or ot QDC9.		21, Sign true of uneral Service Licens	nuo	2	Loring By	ress of Facility Pers Fund	eral Dire	ctors, In	c.
			21. Sign up on Luneral Service Licens 23a. Part 1. Enter the disease, or compleshock, or heart failure. List only of lunerdista Causa (Final	Lemmon ications that caused ne cause on each line	the death. Do r	8728 Libe	erty Rd. ying, such as cardia	, Randal ac or respiratory a	Istown, M rrest,	D 21133 Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a	a consequence	acute	CVA			minutes
	aminer		Conversion list and divine	h	2 001100 001100	ASCV.	∇			1 pars
D	sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence	of):				/
xecute	and al-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequence	of):				
ficate be ex	ysiciar e buri	edicai E		d						
ortifica	ing ph e as fh		IF FEMALE:							
the death cer	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	cy		23d. Date of Month	delivery Day Year
ires that	signed by d be deta	δ	Part II. Other significant conditions co	ntributing to death bu	ut not resulting in	the underlying cause g	given in Part I.		7	e to the cause of death? Probably 4 □Unknown
w requires t	shoul	Completed						24a. Was		autopsy findings available
The la	ite has page 2	mo						autoj perfo 1 ☐ Yes	rmed? deat	to completion of cause of h? Yes 2□ No
cian:	ertifica ector,	Be (25. Was case referred to medical examiner?	Hospital:			Whom	eath (Check only o		
Physi	rthis o raldin	5.	1 ☐ Yes 2 ♣ No 27. Manner of Death	1 Unpatie		Time of 28c. Inj	ury at		dence 6 Other (5	Specify)
Attending	ath. r: Afte e fune	ation	1	28a. Date of Injur (Month, Day	Year) I		fork? □Yes 2□No			
DIVIS el or Atte	s after des al Directo ad in by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.		rm, street, factory, office	8	28f. Location (City or To	Street and Number o wn, State)	r Rural Route Number,
ne Hospit	in 24 hour he Funere oletely fille	edical			examination an	, death occurred at the d/or investigation, in my	opinion, death occ		date and place, and	due to the cause(s)
Totl	with.	Σ	29b. Signature and title of certifier				D3757	3	29d. Date signed (M	74, ZOOY
	V		30. Name and address of person who c	MO	V 52	Type, Print)	Reiste	stewn	ND ZII	36
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Locales				
	i icgioti	- Ell	MAR 3 0 2004	The state of the s		10 mars				

	Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	or Death	Reg	J. No.	3. Time of Death			
ian	Michael Sylves				Month FEBRUAR	Day Yeer 200				
iner 4	4a. Facility Name (If not institution, give : MERCY HOSPITAL	street and number)		own, or Location of Death		4c. County of Dee	th			
r		7. Age (In yrs. last)	birthday) If Under 1 Yrs. Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day,) Apr 1, 1	(ear) 9. Bir 963	thplace (State or Foreignuntry) unk			
tor	Usual Residence of Decedent 10a. State 10b. County MD	10c. City, To	own or Location Baltimore	e			10d. Inside City Limi			
I Director	10e. Street and Number 2915 W. Lanvale St	reet	10f. Zip C	21216	100	. Citizen of What Country?				
by Fur	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No un If Yes, Give Year or Dates:	If Yes, specify	nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	te, etc.			
Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	6a. Decedent's Usual (Give kind of work life. DO NOT use	done during most of work	of working unk 16b. Kind of Business/Industry 1					
To Be Co	unk u 17. Father's Name (First, Middle, Last)	nk	u	nk 18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	unl			
F-	19a. Informant's Name/Relationship (Ty. O • C • M • E •	pe, Print)	and the second second	Street and Number or Rui Street Balti		City or Town, State, .	Zip Code)			
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R 1 □ Donation 5 ☒ Other (Specify)	emoval from State	of Disposition (Name fery, crematory or oth	of		c. Location · City or	Town, State			
9300	21. Signature of Euneral Service Licens Konald		State A	Address of Facility nationy Board re MD 2120		Baltimore	Street			
amluer	3a. P. nti. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Satisfied, list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	l heth	4 1 -	xication		Approximate Interval Between Onset and Death			
Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	gnancy ify)		23d. Date of de Month						
þ	Part II. Other significant conditions cor	ntributing to death but not resulting	g in the underlying cau	ise given in Part I.	23e. Did toba		the cause of death?			
Completed						prior to	utopsy findings availab completion of cause of			
To B	25. Was case referred to medical examiner? Mark 25. Was case referred to medical examiner? Mark 26. Place of Death (Check only one) Mark 27. Place of Death (Check only one) Mark 27. Place of Death (Check only one)									
	(Check only Medical Examin	sician: To the best of my knowled ner: On the basis of examination is				se(s) an manner as				
	Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number CCME PEBRUARY 29,									

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1- State of Maryland / Department of Health and Maryland / Certificate of Death	Mental Hy	giene 200	14 1976
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physic /Medi		Sherry Lee Johnson	March	26, 200	4 2:00 am
1	Exami		4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of De	
1			7101 E. Baltimore St. Dundalk	T	Baltim	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 4 0 Yrs. Months Days Hours Min.	8. Date of Birtl (Month, Day March	v. Yeer)	lirthplece (State or Foreign Country)
	yland sow		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fal	ctor	Md. Baltimore Dundalk			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What (Country?
	s 23e	erai	7101 E. Baltimore St. 21224	7 11	USA	
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f ahow i.a Medical Enaminar must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto If Yes, Give 1 □ Yes 2 ☑ No Specify:	ecny Yes or No- Rican, etc.)	Black, Wi Specify:	nerican Indian, nite, etc. White
200	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	una	16b. Kind of Busines	s/industry
<u>5</u> 5	Mithin ne. then	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	9		
	Hygi ther int,		11 yrs. Cleaning 17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First Middle	Maid Se	rvice
yland	T T T T	To Be	Daniel Lee Collison Virgi	nia L	ee Mace	
Maryl ,	ss 1 and 2 should of Health and Menitem 27 is marker other traumatic		19a. Informant's Name/Relationship (Type, Print) Virginia L. Majors moth r ^{19b.} Mailing Address (Street and Number or Run 7101 E. Baltimore	st. B	r, City or Town, State, altimore	Zip Code) Md. 21224
ر <u>E</u>	Page nent o ant: M arry or		20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetary, crematory or other place) Bayview Crematory	ch 29, 2004	20c. Location - City of Baltimo	
Balt	permit. Departr Importe any inji		21. Signature of Fuperal Service Licenses Connelly Funeral 7110 Sollers Poi	Home nt Rd.	Of Dunda 21222	1k
	Physician /Medical Examiner		23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a shock or heart failure. List only one cause on each line.	or respiratory arr	est,	Approximate Interval Between Onset and Death
	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or righry that inflated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
P.O. Box 6	The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of de Month	Blivery Day Year
rds, P	quires that n signed b uld be deta	d by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		pacco use contribute to	to the cause of death?
Vital Records,	The law requi	omplet		24a. Was all autops perform	v prior to	utopsy findings available completion of cause of
/ital	y sician: The l is certificate ha director, page	BeC	25. Was case referred to medical examiner? 26. Place of Death			\$ 24 140
of V	Physician: this certificatal director, participates	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5 Reside	ence 6 Other (Spe	ecify)
	ting P	Certification:	1 Watural 5 Pending (Month, Day Yeer) Injury Work?	28d. Describe ho	w injury occurred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined determined	28f Location (St	reet and Number or R	tural Pouta Number
	al or A after I Dire d in b	erti	4 Homicide determined determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town	, State)	urar noute Number,
×	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a companient of the companient of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the ca ed at the time, da	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Mon	th, Day, Year)
	1		D24170	1	March 26	,2004
	<u>y</u>		2 H MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Tso MD Richey Hospice \$38 N Eutaw St Bat	timore	MD 213	201
1.0	Sta Registr		MAR 3 0 2004 32. Registrar's Signature Apaulis MAR 3 0 2004			

	Mary			Toca	phson					Month	Day		2004	2:44	PM
al er	4a. Fecility Name (If not institution	n. aive s			, p - 13011	Mara		_	ty of Death						
31 1	Johns Hopki	-	Bayvi		Medicul		y, Town, or B	altim		_			N/A		
	212-03-7043			7. Age (In		Month		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Dec . 24	rth ay, Year) • 191	6	Count	ry)	r Foreign
+		,		10	c. City, Town o	Location							10	d. Inside Ci	ity Limits
to	MD Balt:	lmore	2				Essex							1 🗌 Yes	2 X No
Olred	10e. Street and Number		222			10f. 2	Zip Code				-			ry?	
era				dost Evo	rin II S	3 Mac Day	adopt of H			anifu Van or No				n lodico	
Fun			Armed Fo 1 ☐ Yes	rces? 2 No	I III 0.3.					Rican, etc.)	0-	Bla	ack, White, e	itc.	
þ	3 XWidowed 4 Divorce	b	If Yes, Giv Year or D	re ates:		1 🗆 Yes	2 🖾 No	Specify:				Speci	h: whi	te	
etec	15. Decede (Specify only high	nt's Educ est grade	cation com <i>pleted)</i>		(G	ive kind of	vork done o	<i>duri</i> n <i>a</i> mos	t of work	ing	16b. Ki	nd of E	Business/Ind	ustry	
dwo	Elementary/Secondary (0-12)		College (1	-4or 5+)	"							(Own Ho	me	
Se C	17. Father's Name (First, Middle							18. Mothe	er's Name	e (First, Middle	, Maiden				
2		Ange	elo Bog	ggio				Em	elia	Giano	tti				
	Leona To Land/Dau	ship (Typ gh ter	pe, Pnnt)			_									
		ugiri	er	2	0b. Place of Di	sposition (A	lame of								
	1 Burial 2 □ Cremation		emoval from	State					3/31/	04			•		nd
			18			22. Name	and Addres	s of Facilit	y Cha	rles S				-	
	Habitel	37	DERK			6224	Easte	rn Av	enue	Baltir	more,	Ma	arylan	d 212	24
	shock-br heart failure. Lis	r complic t only on	e cause on e	aused the ach line.				1			irrest,			Interval Bet	ween
	disease or condition resulting in death)	a				cerel	oral	her	norr	hage				hour	2
	Constitution that are adjacen			0, 40 4 00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,										
iner	cause. Enter Underlying	Į		or as a co	ensequence of):										
хаш	that initiated events resulting in death) Last	0	Due to (or as a co	onsequence of):										
	IE EEMALE.														
an/	23b. Was decedent pregnant	23	1☐Live b	irth 2	Fetal death						2				/ear
ysic	1 ☐ Yes 2 No 9 ☐ Unknown				e of death	5 Other	specify)							, ,	-
y Ph	Part II. Other significent condit	ons con	tributing to de	ath but no	ot resulting in th	e underlying	cause give	n in Part I.		23e. Did t	tobacco u	se con	tribute to the	cause of d	eath?
ed b	Diabetes, h	per	tensio	7,	corona	ry a	iten	dise	euse	1 🗆	Yes 2	No	3 🗌 Proba	bly 4 □U	nknown
ple										auto	DSV		prior to com	sy findings a	available ause of
														2□ No	
	examiner?	-	ospital:		- T = D (0)		Othe								
	27. Manner of Death		28a. Date o	of Injury	28b. Time	e of	28c. Injury	at							
atlo	2 ☐ Accident invest	igation	(Mont	n, Day re	ar) Injui	М			No						
ertific			28e. Place buildir	of Injury - ng, etc. (S	Al home, farm, Specify)	street, facto	ory, office		1	28f. Location (: City or To	Street and wn, State)	d Numb	ber or Rural	Route Numi	ber,
	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Phys Examin	er: On the ba	asis of exa	mination and/o	eath occurre investigation	d at the lim	e, date and inion, deal	d place, a	and due to the ed at the time,	cause(s) date and	and ma	anner as sta and due to t	ted. he cause(s)	
ğ	29b. Signature and title of certific	er .	1			2	9c. License	number			29d. Date	signe	d (Month, D	ey, Year)	
	Dr. Rolin	K	Will				RES.	-000	>		Mar	rch	26,	200	4
1	30. Name and address of persor	who cor	mpleted caus	e of death	(Item 23a) (Ty	oe, Print)									
	Physician/Medical Examiner To Be Completed by Funeral Director	S. Social Security Number 212-03-7043	S. Social Security Number 212-03-7043 1	S. Social Security Number 212-03-7043 1	S. Social Security Number 212-03-7043 1 M 2	S. Social Security Number 212-03-7043 1	S. Social Security Number 212-03-7043 1 m 2 m 2 m 5 m 7 328 100. City, Town or Location 102. State 103. County 104. City, Town or Location 104. State 105. County 106. Street and Number 5 Brett Court Apt 328 106. City, Town or Location 106. Street and Number 5 Brett Court Apt 328 11. Marital Status 1 m Never Married 2 m 4 m 7 m 1 m 1 m 2 m 1 m 1 m 2 m 1 m 1 m 2 m 1 m 1	Social Security Number 212-03-7043 Social Security Number 212-03-7043 Social Security Number 212-03-7043 Social Security Number So	Social Security Number S. Sex 212	Social Security Number 1.3 1.3 2.5 7. Age (in yrs. last birthday) 1.0	Social Security Number 6. Sex 10 ms 2 ms 10 ms 2	Second Secure Number Second Second Secure Number Second S	Second Security Number 6. Sex 212-03-7043	Security Number S. 3 Sec 17 Age (h yes) (set britology) Subset (1981	Secretary Number Secretary

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 30 A M **Physician** 28, MARCH 2004 KATHRYN SERENA BARBER KUTCHERMAN /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 2103 OAKSIDE CIRCLE BALTIMORE If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-05-1900 Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F 103 ST. MARY'S Director 220-18-4545 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other then "naturel", or items 23a or 28a-f ahow other traumatic event, the Medical Examinar must be notified at No Yes 2 □ No Director BALTIMORE N/AMD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2103 OAKSIDE CIRCLE 21207 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other then "naturel", or Itel 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ₩idowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DAY CARE PROVIDER SELF EMPLOYED 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be LOTTIE COLLINS WILLIAM HENRY BARBER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2103 OAKSIDE CIRCLE, BALTIMORE, MD 21207 VIOLA SCOTT, DAUGHTER item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or of N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PK 04-01-04 MARYLAND 22. Name and Address of Facility HOWELL FUNERAL HOME 21. Signature of Funeral Service License 4600 LIBERTY HGHTS AVE, BALTO. 21207 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Caucer **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? jo 4☐Pregnant at time of death 5 Other (specify) Yes P.0. 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown dimentia as been sig 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 1 ☐ Yes 2 ☐ No certificate 2 10 No 26. Place of Death (Check only one) After this certific funeral director, 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Assidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death or Attending Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death.
I Director: Af
d in by the fu investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 225663 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 227 CO.IDSPRING LA Buero 31. Date filed (Month, Day, Year) State MAR 3 0 2004 Salle. Registrar

DHMH 17 Rev 1/2001

	State of Maryland / D	epartment of Health and M Certificate of Death	Mental Hygiene 200 L	09768
Physician	Decedent's Name (First, Middle, Last) William E. K	ahl	2. Date of Death Month 28 2004	3. Time of Death 6:20a м
/Medical Examiner	4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	th
Funeral	Ivy Hall Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Middle R: Middle R: Months Days Hours Min. Months Days Hours Min.		
Director State of the control of th	214-14-2327 13C M 2		Sept. 28, 192 2 M	Aryland 10d. Inside City Limits
1,30 Cd. the Maryland the Maryland the Maryland the maryl	MD Baltimore	Middle Rive		1 ☐ Yes 2 🛣 No
5 3- 7 8-04 filter death with the Mainrile as 28 or 28-1 sintertrians 23 or 2	10e. Street and Number 1113 Chester Road	10f. Zip Code 21220	10g. Citizen of What Co	ountry?
δ y	11. Marital Status 1. Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Married 11. Was Decedent Ever in U.S. Amed Forces? 1 Never Married 2 Never M	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify: 	ecify Yes or No- Rican, etc.) 14. Race - Ame Black, Whi	te, etc.
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) uto Worker	ing 16b. Kind of Business	/Industry
S SET E		18. Mother's Name	e (First, Middle, Maiden Sumame)	
Marylar Marylar at 2 should be the and 2 should be the and 27 is marked treumatic of treumatic of To E		Mailing Address (Street and Number or Rura 9226 Bowine Road	· ·	
Fore, M. 1906, M. 190	20a. Method of Disposition 1 20b. Place of cemetry 20b. Place of cemetry 20b. Place of Cemetry 20b. Place of Cemetry 20b. Place of Cemetry	The state of the s	Date 20c. Location - City or	Town, State
Baltimol permit. Pages permit. Pages Depertment of Important. If it any injury or o	'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee		nnellyFuneralHo	
1 20 2 a a	23a. Part1. Enter the disease, or amplications that caused the dark point shock, or heart failure. To only one cause on each line.	300 Mace Ave.	Baltimore MD 2 or respiratory arrest,	Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Myncol P Did to (or as a consequence of	L INFARCTIO	X	Onset and Death
Je.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		EASE	
Box 68760, eath certificate be executed attending physician and for use as the burial-transit cian/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d. 1479LLTEM.	SION		
P.O. Box 68 nat the death certificat d by the attending phyletached for use as the Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	ivery Day Year
be de be de	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco use contribute to	
I Re la The la page 2			autopsy prior to performed? death?	utopsy findings available completion of cause of
Vita Vita sicians sicians certific irector.	25. Was case referred medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outs	Othor	n (Check only one) me 5 ☐ Residence 6 ☐ Other (Spe	cifu)
A F 5 - 1	27. Manner of Death 28a. Date of Injury 28b. Til		28d. Describe how injury occurred	5077
Division C Division C tet or Attending P rs after death. a Director: After t er in by the funers	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, fair building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or Ro City or Town, State)	ural Route Number,
Hospi Funer Funer ical	29a. Certifier (Check only one) 1	death occurred at the time, date and place, of investigation, in my opinion, death occurr	and due to the cause(s) and manner as ed at the time, date and place, and due	stated. to the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)
30	39. Name and address of person who completed eause of death (Item 23a) (T	ype, Print)	Dien Aria NIX	2/222
State Registrar	31. Date filed (Mohth, Day, Year) MAR 3 0 2004	To the contract of the contrac	ny mi it	

			1 - For State Registrar	State of M	/larylan	d / Depa <i>Cei</i>	artment of H	lealth and Death	d Mental Hyg	giene Reg. No.	2001	09769	
i	Physici		Decedent's Name (First, Middle, Las James Kelly	t)					2. Date of Dea Month March	Day 25	Year 2004	3. Time of Death 10:20 am	
	/Medio Examin		4a. Facility Name (If not institution, give	coss Road			4b. City, Town, or Balti			В	County of Death	:e	
	Funeral Director		5. Social Security Number 6. Social Security Number 218-46-0010 1 Usuel Residence of Decedent	X M 2□F	Age (In yrs. I	Yrs.	Months Days		8. Date of Birth (Month, De) Dec. 20	y, Year)	9. Birth Col. Mar	place (State or Foreign intry) yland	
	hours after death with the Maryland turel; or Items 23e or 28e-f show at Exercities must be notified at	Director	10a. State 10b. County Maryland Balt: 10e. Street and Number	imore	10c. City	, Town or Lo	imore			10g Citiz	10d. Inside City Limits 1 □ Yes 25 No Citizen of What Country?		
	J within 72 hours after death with the Marylan Jiene. r than "natural", or Itams 23a or 28a-1 show Ita Medical Examinet must be notified at	Funeral Di	520 Charing Cros	12. Was Decede Armed Force	s?	S. 13. 1	21	229 ispanic Origin? in, Mexican, Pi	(Specify Yes or No- uerto Rican, etc.)	U	S.A. 4. Race - Ameri Black, White	ican Indian,	
2-0030	72 hours aft natural, or dical Everal	by	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	1 ☐ Yes 2 [If Yes, Give Year or Date: ucation de completed)	-	16a. Dece	1 Yes 2 No dent's Usual Occup kind of work done of	during most of	working		Specify: Wh:		
Baitimore, Maryland 21215-0036	를 수 를 는 다	Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4d	r 5+)		n Worker	, 	Name (First, Middle,		eel Gumame)		
Maryiai	should and Men Is marks aumatic	To	Frank Anthony Ke 19a Informant's Name/Relationship (Susan Kelly (Wif	ype, Print)	9-1			and Number or	ille Frank ^{Rural Route Numbe} oad Baltim	r, City or	Town, State, Zi		
ımore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from Sta	te a	lace of Dispo emetery, crer odlawn	sition (Name of matory or other plac Cemetery	3-	Date -29-04	20c. Loc Wood	ation - City or T	own, State	
Bail	permit. Pag Department Important: t any injury o		21. Signature of Funeral Service Licen	X	ed the death	10	630 Edmon	dson Av		nsvi	ille, I 11e, Ma	nc. ryland 21228	
e Sum	Physician /Medical Examiner		hock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a Ac	i line. UTC as a consequ		loid L	euke	mia			Interval Between Onset and Death	
8/60,	ate be executed whysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	с.	as à consequ as a consequ								
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and take 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 Fetal	death 3	Ectopic pregnancy			23	3d. Date of delive	ery Day Year	
rds, P.	w requires that i been signed by should be deta	by	Part II. Other significant conditions o	ontributing to death	but not rest	ulting in the u	nderlying cause givi	en in Part I.	23e. Did to			he cause of death?	
Vital Records,	(4 17	Completed							24a. Was a autop perfor 1 ☐ Yes	sy	prior to co death?	opsy findings available impletion of cause of	
	Attanding Physician: The death. ector: After this certificate by the funeral director, pag	lon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending			ER/Outpatien 28b. Time of Injury	28c. Injun Worl	er: 4 🗆 Nursin	Death (Check only or g Home 5 esid 28d. Describe h	ence 6		(y)	
Division of	tal or Attandi s after death. al Director: A ed in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of	Injury - At ho etc. (Specify	ime, farm, str	eet, factory, office	.03 2	28f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Number,	
	To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Exam	ysician: To the be niner: On the basis and manner	of examinat	wledge, death tion and/or in	vestigation, in my of	pinion, death o	ace, and due to the c ccurred at the time, c	date and p	place, and due t	o the cause(s)	
)	O D With T	X	29b. Signature and title of certifier Hard L	- , MD	f dagth /lt-	22a) (T		602			signed (Month,		
	Sta	te_	30. Name and address of person who TAPA LIN MD 31. Date filed (Month, Day, Year)	401 NO	strar's Signar	SKOAD	_	TIMOR	E MD Z	123	1		
	Registi	ar	MAR3U	2004	1. 1. 1. 1. 1	100	A STATE OF THE PARTY OF THE PAR						

	Decedent's Name (First, Middle, Last)		partment of Health and enlificate of Death	2. Date of Death		3. Time of Death		
ician	Thomas E. Kaiser, J	Or.		Month March 24	Day Yeer	915 a M		
dical niner	4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of De	ath	4c. County of Death			
	45 Leatherwood Place	P. Apt. A 7. Age (In yrs. last birthd	Rosedale	rs. 8. Date of Birth	Baltimo	CO ace (State or Foreign		
	5. Social Security Number 214-94-3277 Heal Residence of Decedor		Months Days Hours Mi		1963 Mar	yland		
	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location		10	Od. Inside City Limits		
ctor	MD Baltimore	Roseda	le			1 ☐ Yes 2 🛣 No		
Dire	10e. Street and Number 43 A Leatherwood Pla	ace	10f. Zip Code 21 237	100	g. Citizen of What Coun United Sta	-		
era	11 Marital Status 12. We		13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - America Black, White, 6	an Indian,		
Completed by Funeral Director	1 X Never Married 2 Married 1.	med Forces? Yes 2 X No Yes, Give ear or Dates:	1 ☐ Yes 2 ☒ No Specify:	and ricall, etc.)	Specify:	White		
leted	15. Decedent's Education (Specify only highest grade com	pleted) (C	ecedent's Usual Occupation Give kind of work done during most of v fe. DO NOT use retired)	vorking 16	6b. Kind of Business/Ind			
dmo	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)	ood Director		Health Ca	LE		
Be	17. Father's Name (First, Middle, Last) Thomas F. Kaiser, S.	Father's Name (First, Middle, Last) Thomas E. Kaiser, Sr. 18. Mother's Name (First, Middle, Maiden Suma Susan Parsons Brad						
2	19a. Informant's Name/Relationship (Type, Pr		failing Address (Street and Number or			Code)		
	Thomas E. Kaiser, 5	r./father 7	Dundas Court T-2					
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov.	cemetery,	isposition (Name of crematory or other place)		oc. Location - City or To			
	*4 □Donation 5 □Other (Specify)	Hilltop	Serv. Corp. 03/		Towson, Mar	-		
	21. Signature of Fungful Service Licens of	S. D. Coster	22. Name and Address of Facility R			,		
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death. Do not use on each line.	enter the mode of dying, such as card	iac or respiratory arres	st,	Approximate Interval Between Onset and Death		
	Immediate Cause (Final disease or condition resulting in death)	Hypertensive Ather	osclerotic Cardiovasc	ılar Disease				
	resulting in deality	Due to (or as a consequence of)	:					
Je.	Sequentially list conditions, any, leading to immediate	Due to (ur as a consequence of)						
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	resulting in death) Last	Due to (or as a consequence of)						
dlcal	d							
Physician/Medic	in the past 12 months?	yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ry Day Year		
ysk		Unknown						
þ	Part II. Other significant conditions contribut Chronic Alcoholism	ting to death but not resulting in the	ne underlying cause given in Part I.		accoluse contribute to th	1/		
Completed				24a. Was an autopsy	24b. Were auto	psy findings available impletion of cause of		
mo				performe	ed? death?			
Bec	25. Was case referred to medical examiner?			Death (Check only one,				
2	Yes 2 No Hospit 27. Manner of Death 1XXNatural 5 □ Pending	al: 1 ☐ Inpatient 2 ☐ ER/Outp a. Date of Injury (Month, Day Yeer) 28b. Tin	ne of 28c. Injury at	Home 5 Residen	ce 6 ⊠Other (Specify v injury occurred	at scene		
Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,		
Medical Ce	(Crieck only 2 Medical Examiner: C	on the pasts of examination and	death occurred at the time, date and pla or investigation, in my opinion, death o					
Med	one) a	and manner stated.	29c. License number	29	d. Date signed (Month, i	Oay, Year)		
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Security Number Security N	Physician										Month	Day			533 A
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1-3 Commission 3	23a o	Future Care	Old Co	ourt			211	33				U.	S.A.		
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Security Security	se C	17. Father's Name (First, M	ddle, Last)			U_L			18. Mothe	r's Name (First, Middle				
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Tablerial 2 Cremation 3 Removal from State Woodlawn Cemetery 03-31-2004 Woodlawn Maryland 21. Signature of Function (Speech) 22. Name and Address of Facility Loring Byers Funeral Director 8728 Liberty Road Randallstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Director 8728 Liberty Road Randallstown, Maryland 21. Signature of Funeral Function Randallstown, Maryland 22. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Byers Funeral Director Randallstown, Maryland 23. Name and Address of Facility Loring Randallstown, Maryland 23. Name and Address of Facility Loring Randallstown, Maryland 23. Name and Address of Facility Loring Randallstown, Maryland 23. Name and Address of Facility Loring Randallstown, Maryland 23. Name and Address of Facility Loring Randallstown, Maryla	e cm	19a. Informant's Name/Rela		e, Print)				•						•	-
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21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Director 8728 Liberty Road Randallstown, Maryland 21 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated season, conditions and the season of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated season of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, indicated assessing in death) and the season of the death of the season of the s	- h-		ation 3 ⊟Re	moval from Si		Place of Dispo cemetery, cre	nsition (Nan matory or o	ne of ther place	9)	Da	te	20c. Lo	cation - C	City or To	wn, State
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Section in the property of the	eny lr once.	21. Signature of Funeral Se	Licensee	/											
The state of the s		shock, or heart failure	se, or complication. List only one	ations that can	used the deat ch line.	h. Do not en	er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,			Interval Between
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25. Was case referred to medical examiner? 1		Hypertens	ien. A	trial	Fib.	illati	on t	Loo	thorn	bid	1 🗆 '	Yes 2[No 3	B 🗌 Proba	ably 4 Unkno
25. Was case referred to medical examiner? 1 Yes 2 No	9 0	/\						/ ¥	/				24b. W	ere autop	sy findings availa
25. Was case referred to medical examiner? 1	should										perfo	rmed2	de	ath?	
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March 28 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	z snouid pleted	25. Was case referred to m	Ho	spital: 1 Lin	patient 2	ER/Outpatie	nt 3□ DO	A Othe	r: 4 □ Nui	rsing Home	e 5 ☐ Resi	dence 6	i □Other	(Specify)
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 27, 5:57 p M Henry Leonard Keller 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun 2, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 M 2 □ F 73 Yrs. Days Country) Maryland 213-26-3335 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28a-1 show any injury or other traumatic event, the Medical Examination in Item Milled #1 once. 1 ☐ Yes 2 ☑ No Baltimore Baltimore Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2302 Putty Hill Avenue 21234 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 51-5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education 16a. (Specify only highest grade completed) Newspaper Elementary/Secondary (0-12) College (1-4or 5+) Deliveryman 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Henry Leonard Keller Helen Gallagher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Mary Keller/Wife 2302 Putty Hill Avenue, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Mar 30 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Chesapeake Crematory 2004 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ²² Cremation and Funeral Alternatives 2890am Auls 8717 Green Pastures Drive Baltimore, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Immediate Cause (Final disease or condition **Physician** Morth resulting in death) /Medical Due to (or as a cons-quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Holynknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2000 certificate 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To tha Funaral Diractor: A investigation 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitaf Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To tha 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print)

And Address of person who completed cause of death (Item 23a) (Type, Print)

And Address of person who completed cause of death (Item 23a) (Type, Print)

And Address of person who completed cause of death (Item 23a) (Type, Print) AOUTON 32. Registrar's Signature 31. Date filed (Month, Day, MAR 3 0 Year) 2004 Annel 1 Registrar

HENRY

State of Maryland / Department of Health and Mental Hygiene $200\,$ L 09773 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Edith Marie Kindberg 2004 20, March :00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Augsburg Lutheran Home Lochern
If Under 1 Year | If Under 24 Hrs. <u>Baltimore</u> 8. Date of Birth (Month, Day, Year) March 25,1918 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕅 F Yrs. Director 218-10-2662 85 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f ehow the Medical Exercitive must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Lochern 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **І**тетв 23a Funeral 21207 U.S.A. death Campfield Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 21215-0036 *naturel', or 1 ☐ Yes 2√☐ No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then , Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Accounting Technician 12th. Grade Commercial Credit Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil.
Department of Health and Mental ty,
Important: If liem 27 le marked oth
any injury or other traumattc evenions. Be August William Minnie Beyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Romero 3035 Chesterfield Ave. Baltimore MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 3/24/2004 Baltimore 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 6415 Belair Road Baltimore 23a. Part1. Enter the disease, or come shock, or heart failure that only Approximate Interval Between Onset and Death cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, plications that caused the one cause on each line Immediate Cause (final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence ol) Box 68760. physician by Physician/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown á Records, P. signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 🗌 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident Director: 6 Could not be 3 🗀 Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funeral Dire 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 23 2004 Cleak 30. Name and address of person - o completed cause of death (Item 23a) (Type, Print) HETCHTE AVENUE Durah 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar MAR 3 0 2004

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Year 2004 Month KARITIS ROSALIE 10:45 PM MAKCH 18 4b. City, Town, or Location of Death 4e Facility Nama (ff not institution, giva street end number) 4c. County of Daath TOLNA STREET BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Deys Hours Min. Feb. 1,1927 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 7. Aga (In vrs. lest birthday) 6. Sex 1□ M 2□ F Months 234-42-9645 77 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 10e Stete 1 ☐ Yes 2 ☐ No Baltimore N/A 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 834 Tolna Street 21224 U.S.A. 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher Education 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Elmer Stonestreet Anna May Dayton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Numbar or Rurel Routa Numbar, City or Town, State, Zip Code) Ulysses Karitis-husband 834 Tolna Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greek Orthodox Cemetery 3/22/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licensee 6224 Eastern Avenue Baltimore, Maryland 21224 23a. Pent Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, show or heart failure. List only one care in reach line. Approximata Intarval Batween Onset end Death Immediata Causa (Final diseasa or condition resulting in death) Massive intracianial bleed with midline shift Dua to (or as a consaquanca of) Hyputensim Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consaquanca of) Due to (or es e consaquence of) 23b. Did tobecco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? DEEP VENOUS THROMBOSIS, RT CEREBROVASCULAR ACCIDENT, HYPERCHOLESTER OLEMA, ANTICOAGULATION INR 1.7 (idea) 1 ☐ Yes 2 ☐ No 1 Tes 21 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4□ Nursing Homa 5 Rasidance 6 □Other (Spacify) 1 Yes 2 No

Be Completed by Physician/Medical Examiner the burial-trensit or Attending Physician: The law requires that the death certificate be asscuted Division of Vital Records, P.O. Box 68760, : Aftar this cartifica e funeral diractor, p Certification: To eftar death.

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

MD

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentel Hygiane.

ant: If item 27 is marked other than "naturel", or items 23a or 28a-f show ury or other traumetic event, the Medical Examinar must be notitied at

injury or Department important: If

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKIN SONS DISEASE, ARTHRITIS, COMPLEX PARTIAL SEIZURE

25. Was case referred to medical examiner?

28d. Describa how injury occurred

27. Manner of Death 28e. Date of Injury (Month, Day Year) 1 Natural 2 Accident 5 Panding invastigation

28c. Injury et Work? 28b. Tima of Injury 1 Yas 2 No

28f. Location (Street and Number or Rurel Routa Number, City or Town, Stete)

6 Could not be datarmined 3 ☐ Suicide 28a. Plece of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 \(\text{Homicide} \)

154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) end manner stated.

(Check only one) 29b. Signature and title of certifier

29c. Licensa numbe

29d. Data signed (Month, Day, Year) 04 23

m 30. Nama and eddress of person who completed cause of deeth (Item 23e) (Typa, Print)

HOPKINS BALTIMORE, MD 5505 BAYVIEN CIRCLE JOHN BURTON, MD 31. Data filed (Month, Dey, Year)

State Registrar

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filled in

29a. Certifier

To the Hospital of within 24 hours of To the Funerel D completely filled i

MAR 3 0 2004



permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or Iteme 23a or 28a-f ehow any injury or other traumatic event, the Madical Examiner must be putilised at once. Baltimore, Maryland 21215-0036 **Physician** /Medical Examiner The law requires that the death certificate be executed as the burial-transit P.O. Box 68760 esn should be detached Records, page 2 Vita or Attending Physicien: funeral director, of Division after death. in by the within 24 hours aft To the Funerel Di completely filled in 3

Physician

/Medical

Director

Completed by Funeral

Be

2

Physician/Medical Examiner

Completed by

Be

Medical Certification; To

29a. Certifier

29b. Signature and title of certifier

Hany Backer

31. Date filed (Month, Day, Year)

Flosa, hie

Examiner

Funeral

Director

Ilizabe +1

atiant known as

State Registrar

DHMH 17 Rev 1/2001

MAR 3 0 2004

Dashandy

32. Registrar's Signature Leken

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1411)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner. On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

Hospital of Bultimore

29d. Date signed (Month, Day, Year)

March, 26, 2004

Sinon

		1	State Amend Item 21 per Di	ate of Maryland /R,03/30/04dhb	/ Depa	rtment of Hotificate of E	ealth and M Death	ental Hy	giene 2 (004	09776	
			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death	
	Physicia /Medic	al	Pamela S.		vson			March	13	2004	1:32 p ^M	
1	Examin		4a. Facility Name (If not institution, give street	and number)	İ	4b. City, Town, or			4c. County	of Deeth Arund	51	
			904 Autumn Valley Lane 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	Gambrills If Under 1 Year	If Under 24 Hrs.	8. Date of Bir			ace (State or Foreign ry)	
П	Funeral Director		172-34-6885		Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da April 2		Pennsy		
	σ	h-	Usual Residence of Decedent								od. Inside City Limits	
	anylan show	- 1	MD Anne Arunde		Town or Lo	Gambrills					1 ☐ Yes 2 ☑ No	
	he Me	Director	10e. Street and Number	<u> </u>		10f. Zip Code			10g. Citizen of	What Count		
	with le or		904 Autumn Valley Lane			101. 2.5	21054		•	USA	,	
	Jeath ms 20	Funeral	11 Marital Status 12. W	as Decedent Ever in U.S.	. 13. V	Vas Decedent of His	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No	- 14. Rac	ce - America		
36	be filed within 72 hours after death with the Maryland ital Hyglene. id other than "naturel", or items 23e or 28e-f show event, the Medical Examination must be ricitlized at	by Fur	1 Never Married 2 Married	med Forces? □Yes 2 ☑ No Yes, Give ear or Dates:		Yes 2 No	Specify:	rticari, etc.,		b: White		
Maryland 21215-0036	72 hou	Completed	15. Decedent's Education (Specify only highest grade com			lent's Usual Occupa	ition Juring most of worki	ng	16b. Kind of B	usiness/Ind	lustry	
21	ithin Jan	nple		ollege (1-4or 5+)	life. L	OO NOT use retired,)					
7	filed with Hygiene. other than		17. Father's Name (First, Middle, Last)		Regi	onal Coordi	18. Mother's Name	(First, Middle		king ne)		
and		Be c	Frederick Siever	ς.				Mildred				
2	d 2 should be th and Menta 7 Is marked traumatic ev	ဥ	19a. Informant's Name/Relationship (Type, P		19b. Mailin	g Address (Street a	nd Number or Rura			, State, Zip	Code)	
	nd 2 illth a 27 ls r tra		William Lee Laws	on (Husband)	90	4 Autumn Va	lley Lane,	Gambrill	s, MD 21	054		
ore,	es 1 and of Healt I Item 2 r other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remove	Cer	netery, cren	sition (Name of natory or other place	9))ate	20c. Location			
Ĕ	Pag ment ant: h		* 4 ☐Donation 5 ☐ Other (Specify)	Maryla		erans Cemet		/2004	Crownsvi			
Baltimore,	permit. Pages I Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licensee Brian Clymer per	DVR	22	. Name and Addres	s of Facility Ha Ridgely Ave		uneral Ho apolis, M			
П			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one can	ns that caused the death.	Do not ente	er the mode of dying	g, such as cardiac c	or respiratory a	rrest,		Approximate Interval Between	
1	Fhysician		Immediate Cause (Final disease or condition	Non 13 de	cdl	Obn Cas	ur				Onset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						, ,	
н		<u>.</u>	Sequentially list conditions, b. —	Due to for as a conseque	ence of):					-		
0	uted 1 ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	execu an and rial-tra	Exa	resulting in death) Last	Due to (or as a conseque	ence of):							
8760,	icate be executed physician and s the burial-transit	dlcal	d									
9	ertifica ling p	(a)	IF FEMALE:	yes, outcome of pregnan	·CV				224 D	ate of delive	n/	
Вох	eath certific attending p I for use as I	Physiclan/M	in the past 12 months?	Live birth 2 Fetal of Degrant at time of dea	death 3	Ectopic pregnancy Other (specify)					Day Year	
o.	that the de led by the detached	ysic		Unknown							- VI-12 VI-12 VI-12 VI-12 VI-12 VI-12 VI-12 -	
Δ.	res that signed b		Part II. Other significent conditions contribu	ting to death but not resul	ting in the u	nderlying cause give	en in Part I.	23e. Did 1	23e. Did tobacco use contribute to the cause of death? 1 Ses 2 No 3 Probably 4 Unknown			
Ö	w require been si should b	eted	- C 19/04 C					24a. Was	an 24h	Were autor	osy findings available	
Records,	a 5 CA	Completed by						auto	psy ormed? 225No	death?	osy findings available inpletion of cause of	
Vital	cian: ertific actor,	Be	25. Was case referred to medical examiner?	and.		Oth	26. Place of Death					
of/	Physic this o	5	1 ☐ Yes 2 ☐ Hospi 27. Manne of Death 28	1 _ Inpatient 2 _ E	R/Outpatier 28b. Time of		ar: 4 ☐ Nursing Ho		idence 6 Ot how injury occu		')	
uc.	ding I h. After funer	tlon	1 Natural 5 Pending	(Month, Day Year)	Injury	Work	k? Yes 2 □ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
Division	or Attendent frer deat Director: in by the	Certification;	2 Accident	se. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office			Street and Num wn, State)	ber or Rura	l Route Number,	
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		(Check only 2 Medicel Exemiper:	n: To the best of my know	vledge, deati on and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and m	nanner as st , and due to	ated. the cause(s)	
	thin 2 the inthe inthe interpretation	Medical	29b. Signature and tiple of certified	and manner stated.		29c. License	e number		29d. Date sign	ed (Month, i	Day, Year)	
	ř ¥ ř S		1/1/104			DTT	665		Hurd	1/6	2004	
	10		30. Name and address of person who comply				1	75	(/	11	1 11	
	1		31. Date filed (Month, Day, Year)	32. Registrar's Signati	Uni	verity of	401, Cal	(L)	. breeze	1+1	1sht from	
	St: Regist	ate rar	MAR 3 0 2004	even & A	mente							

		cht 1 - State Registrar 1. Decedent's Name (First, Middle, Lasi			ertificat	e or L	Jeani	2. Date of D			09								
Physicia		Brian J. Leuc						Month Day Yeer				M							
/Medica Examine		4a. Facility Name / If not institution, give 8502 Kavanagh	street and number) Road			Town, or	Location of De		4c. Cour	4 ity of Death timore	925	<u>a "</u>							
Funeral Director		5. Sociat Security Number 6. Se		e (In yrs. last birtho	Months	1 Year Days	If Under 24 H	in. (Month, D	irth lay, Year)		lace (State	or Foreig							
a-f show	ctor	10a. State 10b. County 10c. City, Town or Loc Dundalk								1	0d. Inside (City Limit							
23a or 28 ust be no	rai Director	10e. Street and Number 8502 Kavanagh Roa	ıd		10f. Zip 212				10g. Citizen o	f What Cour	ntry?								
"natural", or Items	by Funerai	11. Marital Status 1 ↑ ↑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		3. Was Deced If Yes, spec	ofy Cubar	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)		ace - Americ ack, White, ify:		te							
nar hygiane. nd other than "natural", or Items 23s or 28s-1 showert, the Mudical Examiner must be notified at	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		(G	cedent's Usua ive kind of wor a. DO NOT us	rk done d	uring most of v	vorking	16b. Kind of N/A	Business/Ind	dustry								
n and Menal Hyglene. 7 is marked other than " Iraumatic event, the Mark	To Be C	17. Father's Name (First, Middle, Last) Paul Christian Le	eucht					lame (First, Middle Susan Noc	, Maiden Suma	ıme)									
- N -		19a. Informant's Name/Relationship (7) Paul Christian Le			ailing Address Kavan			Rural Route Numb Dundalk,		n, State, Zip 222	Code)								
Department of their Important: If Item eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Discemetery, of Metro	rematory or or	ther place		Date 29-04	20c. Location Baltin										
Import eny inj		21. Signature of Theyal Service Liouns Edward A	egorchik		22. Name an Cremat 299 Fr	d Address ion eder	s of Facility Society ick Roa	of MD ad Balt	Inc.	MD 2	1228								
ysician ledical aminer		23a. Part1. Enter the disease, or complished, or heart failure. List only of the failure is only of the failure is only of the failure is only of the failure is only of the failure is only of the failure is only of the failure is only of the failure is only of the failure is only on the failure is	aDue to (or as	100 2109	enter the mode	e of dying	, such as card	iac or respiratory a	rrest,		Approxima Interval Be Onset and	tween							
	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last).).	a consequence of):		****													
by the attending phy tached for use as the	ysician/Medic	Physician/Medic	ysician/Medicai	ysician/Medic	ysician/Medic	ysician/Medic	ysician/medica	ysicianymedica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3□Ectopic pre 5□ Other (spe					ate of delive		Year
igne be d	ò	Part It. Other significant conditions cor	ntributing to death bu	ut not resulting in the	underlying ca	iuse givei	n in Part I.	23e. Did t	obacco use cor Yes 2 No	atribute to the		death? Unknown							
8 4	Completed							24a. Was auto perfo 1 Yes		Were autop prior to con death? 1 A Yes	sy findings apletion of c	available ause of							
direc	0	25. Was case referred to medical	lospital: 1 🗌 Inpatier	nt 2 ER/Outpat	ent 3 DO	Other		eath (Check only of Home 5 Resi	one) dence 6 ∑ Ot	her (Specify	at s	cene							
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y uc Jo 8b. Time year) Injur	00 M	Bc. Injury : Work? 1 🗆 Ye	at BS 2 No		how injury occu		26/4								
		3 Suicide 6 □ Could not be determined		(Specify)	NOW	12		8507	(12)	EDS	Kee	berg							
To the Funeral I	edic	29a. Certifier 1 Certifying Physical Check only one) 1 Certifying Physical Examination (Check only one)	ner: On the best of and manner sta	examination and/or	ath occurred a investigation,	it the time in my opi	n, date and plan nion, death oc	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as sta and due to	ited. the cause(s	¿)							
To con	Σ	29b. Signature and title of certifier	lioni	- Ble	29c.	OCIV			29d. Date signe March										
		Mame and address of person who co	mpleted cause of de	eath (Item 23a) (Type	e, Print)		- G+	et, Balt:	imorco I	40mm10	nd 21	201							

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** March 28, 2004 Jennifer H. Link 9:50A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 18 Scottsdale Court Lutherville
If Under 1 Year | If Under 24 Hrs. <u>Baltimore</u> SEP 17, 1975 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 28 215-96-1919 Yrs. Director Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23s or 28s-f showing Medical Examiner is ust be notified at 1 Yes 2 No Maryland Directo Baltimore Lutherville 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? death v 18 Scottsdale Court 21093 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 XNo If Yes, Give Year or Dates: 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A Never Worked 0 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George A. Link, Jr. Pamela W. Sexton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Scottsdale Court Pamela W. Link/Mother Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 3/29/04 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service-ticensee

Edward A. Gregorchik Cremation Society of MD, Inc. 299 Frederick Road Baltimore poce MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ruse /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. the 9☐ Unknown 9 🗆 Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death Check on one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident completely filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) march 28 2004 liques. M-D Troop Cu 08351 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 cackeyevelle Mi) JOSE A-AGILTO 54 SCOTT ADAM 31. Date filed Month Day, Year 1304 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20041 - For State Ragistra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Lehr **Physician** 730 AM mma march 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Assisted Living Howard Columbia Sunrise If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept. 7, 1906 MD Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 2 📉 F 216 031 891 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State Itams 23a or 28a-f ehow ir than "natural", or Itams 23a or 28a-f ehor The Modical Exercities to ust be notified at Director 1 ☐ Yes XXNo MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 Freetown Road Funeral 21044 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23, ury or other traumatic event, I're Marical Extensional and other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XIXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ **¾**□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Administrative Asst. Fed. Gov't 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Rollman Alvine Waldeck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11216 Ridermark Row, Columbia, Md. 21044 Linda J. Wilson/niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Balto/Wash.Crematory 28/2004 Laurel, Md. permit. Page Department of Important: If any injury or 22. Name and Address of Facilit Witzke Funeral Homes, 21. Signature of Funeral Service Lizensee 5555 Twin Knolls Rd, Columbia, Md. 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastro intestinal Bleed days Priysician /Medical coagulopath Examiner Sequentially list conditions, if any, leading to in module cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by aurhz valve, on Coumadin 1 ☐ Yes 2 Who 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 1 🗌 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 AOther (Specify) A45.5+ 1 ☐ Yes 2 XNo Certification: To his 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

4

Road,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hickory

31. Date filed (Month, Day, Year)

MAR 3 0 2004

Ridge

D5653

co lumbia

march 26, 2004

MD 21044

State of Maryland / Department of Health and Mental Hygiene For State Registra 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Dorothy Marie Letschin MARCH 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BEL AIR

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

May 3, 1931 MARINER HEALTH OF BEL AIR HARFORD 5. Social Security Number **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🛣 F Maryland 213-28-1308 Director 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show 10d. Inside City Limits Harford Maryland Jarrettsville Director 1 Tyes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3543 Anderson Lane 21084 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status r than "natural", or items the Medical ExaminaTo filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. markad other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic traumatic evant, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any injury or other traumetic evant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Francis Gos ပ Frances Zisk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank Letschin- Son 3539 Anderson Lane, Jarrettsville, Maryland 21084 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 04/01/04 Baltimore, Maryland 21. Signature Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes, P.A. 401 S. Chester Street, Baltimore, Maryland 21231 23a. Part1. Enter the disease, of shock, or heart failure. List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition neumonia Priysician /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical The law requires that the death certificate the attending phys IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy detached for Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by pe 3 ☐ Probably 4 ☐ Unknown 2 should 1 🗌 Yes 2 X No 24a. Was an Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No this certificate has I page. Vital 1□ Yes 20 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2√ No Certification: To 3□ DOA of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Medical 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and the of contifier 29c. License number D3465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 134SWELL MINUE Mac 31. Date filed 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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		1 - For State Registrar	State of	Marylan			of Health of Death			ene g. No. 20	004	0978
Physic	ion	Decedent's Name (First, Middle, I						2	Date of Death	Day	Year	3. Time of Death
/Medi		R. Kent Lanca							MARCH	EL,	2004	09:50 PM
Examiı	ner	4a. Facility Name (If not institution, g Saint Joseph	Medica	1 Cent				OWSOT		4c. County	alt:	imore
Funeral Director		5. Social Security Number 578-42-5132	Sex 7. 1 ☑ M 2 ☐ F	. Age (In yrs. I	last birthday) Yrs.	Months D	Year If Under Pays Hours	Min. N	Date of Birth (Month Day, [ar 6,	928	9. Birthp Coun Miss:	lece (State or Foreign try) ISSIPPI
, a d		Usual Residence of Decedent 10a. State 10b. County		100 Cin	y, Town or Lo	cation						04 (
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-1 show raumatic event, if a Medical Exertities in the sound in a marked other than "natural".	or	MD Baltim	ore		owson	Cation					1	0d. Inside City Limits 1 ☐ Yes 2X No
28a-	rect	10e. Street and Number				10f. Zip Co	ode		10	g. Citizen of W	/hat Coun	try?
h with	al Di	8430 Charles Va	lley Cour	ct			2120)4			USA	
ems er re	Funeral Director	11. Marital Status	12. Was Decede	es?	S. 13. \	Vas Deceden f Yes, specify	t of Hispanic Or Cuban, Mexica	rigin? (Specifin, Puerto Ric	y Yes or No-		- Americ	
s afte	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	:□No es: 1953		I□Yes 2X				Specify:		ite
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should nd Me mark matic	2	19a. Informant's Name/Relationship	(Type, Print)	_	19b. Mailin	g Address (S	treet and Numb				State. Zip	Code)
and 2 sealth ar n 27 is		Evelyn Lancast		:	843	0 Char	les Val	ley Co	urt Tov	son, M	D 21	1204
of Hei		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	□ Romoval from St		lace of Dispo	sition (Name natory or othe	of r place)	Date	9 20	Oc. Location - (City or To	wn, State
Pagas ment of lant: If Its		* 4 X Donation 5 □ Other (Spe	city)	219								
partitioner, Man yiellin 2.12.1.3.0000 permit. Pagas 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exercities It is notified an once.		21. Signature of Funeral ervice Lic	White	irecto	or St Ba	Name and A	atomy B	Boardos	55 W. I	Baltimo	re S	treet
52.		23a. Part1. Enter the disease, or co shack, or heart failure. List on	mplications that cau	used the death								Approximate Interval Between
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal		d								111	
n certificanding plans as t		IF FEMALE:	220 If you guton	omo of program	201						11.7	
attende for us	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		h 2 ∏ Fetal nt at time of de	death 3	Ectopic pregr				23d. Date Mon		ry Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		Juli 5 (- Ciriei (Specii	<i>y</i> /					
s that ned b	by Pł	Part II. Other significant conditions	contributing to deaf	th but not resu	ulting in the ur	derlying caus	e given in Part l		23e. Did toba	cco use contril	bute to the	e cause of death?
requires (led t								1 🗆 Yes	2 □ No 3	3 🗌 Proba	ubly 4 Unknown
law nas be	Completed								24a. Was an autopsy	24b. W	ere autop	sy findings available
n: The licate t	Con								performe 1 ☐ Yes 2	d? de	eath?	No
sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital: 1 Inp				Othor	2000	Check on one			
Physic refuse or all di	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	Injury	P/Outpatient 28b. Time of		4 □ Nu Injury at		5 Resident)
nding ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investigat		Day Year)	Injury	м	Work? 1 ☐ Yes 2 ☐					
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To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2			4									
Hosp 24 ho Funa stely fi	Medical	29a. Certifier 1 Certifying 1 (Check only one) 1 Medical Ex	Physician: To the be aminer: On the basi and manner	is of examinat	wledge, death ion and/or inv	occurred at to estigation, in	he time, date an my opinion, dea	nd place, and oth occurred	I due to the cau at the time, date	se(s) and man a and place, ar	ner as sta nd due to	ited. the cause(s)
ro tha vithin ro tha	Me	29b. Signature and title of certified	1 1		P	29c. Li	cense number		290	. Date signed	(Month, D	a, Year),
F > F 0		> M	11	9		DE	2096		C	3/2	23/	09
		30. Name and address of person wh	o completed cause	of death (Item	23a) (T pe, i	Print)				- 1	- 1	
- 41-2-12-1		DAVID UTZSCHN				LER D	RIVE.	BALT	IMORE.	MARYLA	AND	21204
Sta		31. Date filed (Month, Day, Year) MAR 3 0 2004	32. Reg	istrar's Signat	ture							

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Month Year **Physician** James E. Lingham

4a. Fecility Name (If not institution, give street and number) 9:20 AM 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner T. Age (In yrs. last birthday) II Under 1 year II Under 24 Hrs. Baltinge BAYVIEW Care Center 9. Birthplace (State or Foreign Johns Hapkins Sink 8. Date of Birth (Month, Day, Jan 8, 5. Social Security Number **Funeral** Months Days Hours Min Country) MD 1**⊠**M 2□F 65 Yrs. 219-34-0246 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Baltimore White Marsh 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21162 6300 Days Cove Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Commercial College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Importent: if Item 27 is marked other than eny injury or other traumatic event, Ins. 2008. Laborer Construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Dorsey Maxine Lingham 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leona Lingham/Wife 6300 Days Cove Road, White Marsh, MD 21162 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Mar 30 Chesapeake Crematory Beltsville, MD 2004 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives MO 0986 strill 8717 Green Pastures Drive Baltimore, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cell 50 vamous Carcinoma UPRIS resulting in death) /Medical Que to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy lor Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ₽ Onknown 1 Yes 2 No Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes Physicien: funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 INatural 5 Pending 1 Yes 2 No hours after death. unerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel I To the Hospitel 1 Providing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 0 anlong 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sy view Circle Baltimore MD 21224 F. Bellanton mo 32. Registrar's Signature Michele 31. Date filed (Month, Day, Year) State 2004 MAR 3 0 Registrar

DHMH 17 Rev 1/2001

ADH DIANA MARTINEZ Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04 - 1978Unknown 04-088 State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** INE Z Mar 0855 A Diana MARCH 20, 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4117 E. LOMBARD STREET BALTIMORE CITY If Under 1 Year if Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11 - 3 - 21 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 82 Months 258-36-2611 Yrs Pues Director +0 B Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-1 show other traumatic event, the Medical Examiner must be notified at Baltimor 1 Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 238 212 45A Lombard 24 death v or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Rece - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Hispanic 3 ☐ Widowed 4 ☐ ivorced ear or Dates "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinnent of Health and Mental Hygiene.
ant: If item 27 is marked other than ury or other traumatic event, Ine M 16 17. Father's Name (First, Middle, Last) UNKNOWN Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19a. Informant's Name/Relationship (Type, Print) 2122 20b. Place of Disposition (Name of cemetery, crematory or other place) ON FRIEND Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Rosar HOLS 4 ☐ Donation 5 ☐ Other (Specify) Dund MD. 22. Name and Address of Facility WES 18 Y Chavis 2007 Eastern 21. Signature TI Baltimole 21231 AVR 23a. Part1. Enter the disease, or complication to shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition INHALATION **Physician** AND THERMAL SMOKE /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Hospitel or Attending Physician: The law requires that the death certificate be executed Exami and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. the attending physician by Physician/Medical IF FEMALE: 9Sn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 □Ectopic pregnancy ō Month Year Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, å 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1X Yes 2 □ No this filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After SVBTECT WAS IN DWELLING-THAT CAVGHT F RE 281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Natural 5 Pending investigation Injury death. 2 Accident 3 Suicide 3/20/04 1 ☐ Yes 2 ☑ No 8:4 7 AM after death 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide RESIDENCE 4117 E. LOHBARD ST, BALTIMORE, 10 within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month. Day, Year) OCME MARCH 21, 2004

DHMH 17 Rev 1/2001

State Registrar

WAR 3 0 2004

RNB10,

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31. Date filed (Month, Day, Year)

30. Name and adoress of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature Betwee & Sparks

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** MAHONEY **JOSEPH** MARCH 20, 2004 AUGUSTUS 4:38 PM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 58th Ave. **Bladensburg** Prince George's If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Deys 18 M 2□ F Months Director 578-40-1809 1927 Washington DC Usuel Residence of Decedent with the Maryland 10e. State 10d. Inside City Limits 10b. County 10c. City. Town or Location 7 is marked other than "natural", or terms 23s or 28s-f shor traumetic event, the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Funeral Director Prince George's Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4202 58th Ave. parmit. Pages 1 and 2 should be filled within 72 hours after death 1 Department of Health and Mantal Hygiena. Important: if flem 27 is marked other than "nature!" — may injury or other traumatic average. 20710 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 /01 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 11/01/45
1 X Yes 2 N 11/01/45
If Yes, Give Year or Dates: 12/01/46 1⊠ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Maintenance Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Richard Mahoney Margretta Johnson 19e. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) TaLoria Mahoney-Davis /in- law 3920 Carthage Rd Randallstown MD 21133 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other p 20c. Location - City or Town, State 12CXBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 4 ☐ Donetion 5 ☐ Other (Specify) 3/29/2004 Cheltenham MD Vetrans Cemetery
22. Name and Address of Fecility 21. Signa p of Funeral Service Licensee Alexander S. Pope Funeral Home 2617 Penn Ave SE Washington DC 20020 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on eech line. Approximate Interval Between Onset and Death) Physician Immediate Cause (Final disease or condition resulting in death) /Medical CARDIO-PULMONARY ARREST Examiner Due to (or es a consequence of): Physician/Medical Examiner CORONARY ARTERY DISEASE or Attending Physician: Tha law raquires that the death cartificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, **DIABETES MELLITUS** Due to (or es e consequence of): Aftar this cartificata has been signed by the funaral director, page 2 should be datached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? t □ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 1 Yes 2 No Other: 4□ Nursing Home 5 x Residence 6 □ Other (Specify) Certification: To 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigetion aftar daath. neral Director: A fillad in by tha f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral (tell Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) Medicai d title of de title 29b. Signature 29c, License number 29d. Date signed (Month, Dey, Year) MD32928 MARCH 25, 2004 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) JEFFREY D. SCHWARTZ, M.D., VAMC, 50 IRVING STREET, N.W., WASHINGTON, DC 20422/688 Registrer's Signature

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Roger James McGee 1:35 PM^M 2004 March 28 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 11785 Lone Tree Court Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 5, 1935 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** New York 1√2 M 2□ F Months Days Hours Min. 055-28-9793 69 **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d, Inside City Limits "natural", or itams 23a or 28a-f show injury or other traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 🔯 No Columbia Director Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 11785 Lone Tree Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 TYes 2 No If Yes, Give Year or Dates: 1954-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced 1957 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. markad othar than Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer Westinghouse permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If Itam 27 Is marked othingny injury or othar traumatic event, 9069. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (James McGee Evalena Galliford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. McGee/Wife 21044 11785 Lone Tree Court Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory Inc. 3-29-04 Baltimore, MD 21. Signature of Funeral Service Edward A. ²², Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD Edward A. Gregorchik

299 Frederick Road

Baltin

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Neuro en do Crine Immediate Cause (Final disease or condition resulting in death) meta static Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 5 esidence 6 ☐ Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funaral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 4113 March 29, 2004 Ma 1

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State Registrar Clement B. Knight, MD

11065 Little Patuxent Parkway
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Columbia, MD

			For State	State of Maryland	/ Department of Health a	and Mental Hygier	ne 2001	0070-
			Registrar 1. Decedent's Name (Figst, Middle, Las	0	Certificate of Death	Reg. I	G 47 0 1	3. Time of Death
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	Maryland n-f ehow illind at	tor	10a. State 10b. County	10c. City, 7	Town or Location 141 moRE		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with the 23s or 28s	ai Director	10e. Street and Number	VALE ST.	10f. Zip Code	10g.	Citizen of What Coun	ntry?
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Baltimore,	nit. Pages 1 and artment of Healt ortant: If item 2 injury or other		20a. Method of Disposition 1	Removal from State	te of Disposition (Name of letery, crematory or other place)	Date 200	. Location - City of To RBh + 45	own, State
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funeral Service Licen	Jams ones	AR Sharp and Address of Facility	JUNES, JA	Sto mo	21213
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)		30. Name and address of person who	completed cause of death (Item 2	(Type, Print) 「O)にCハ Pハ(いで	- Towson L	no T	0 2004
	Sta	ite	31. Date filed (Month Day, Year)	A2. Registrar's Signatu				

		For State Registrar	State of Mary		artment of H			giene Reg. No. 6	2006	0978	
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/Medic	al	George David Mc 4a. Facility Name (If not institution, giv.			4b, City, Town, o	r Location of Deat	MARCH	40.0	2004 County of Death	10:40 P	
xamin		MARINER HEAL 5. Social Security Number 6. S	THO F BELF	AIR	BEL If Under 1 Year	AJR If Under 24 Hrs	8. Date of Birth		ARFOR	D (State or Earch	
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Item 27 Is r other trai	1 (8	20a. Method of Disposition	1	20b. Place of Dispo	osition (Name of matory or other plac	сө)	Date	20c. Loc	ation - City or T	own, State	
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ne Funeral Director: A pletely filled in by the f	Certification:	3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, st Specify)	reet, factory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
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- 14	Š							29d. Date	d. Date signed (Month, Day, Year) North 23rd, 2004		
To the	-	14	mp		Doc	5660	/ /	Mar	ch 23	14, 2004	

DHMH 17 Rev 1/2001

GEORGE MORRISON

		1	For State Registrar	State of Maryland / D	epartment of Health Certificate of Death		iene 2004 09788
	Physicia		Decedent's Name (First, Middle, Last	De in men	20115	2. Date of Deat Month	Day Year
)	/Medic Examin	al -	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location	of Death	4c. County of Death
	Funeral		36/8 ANNE HA 5. Social Security Number 6. Se			r 24 Hrs. 8. Date of Birth Min. (Month, Day,	Year) 9. Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	M 2 F 52	Yrs. Months Days Hours	06-02	-51 south) N Y.
	laryland show		10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits 1 ☐ Yes 2 No
	th the N or 28a-f	Funeral Director	10e. Street and Number	OKC 1	10f. Zip Code	1	0g. Citizen of What Country?
	ms 23a	eral [308 Anne HOH	12. Was Dededent Ever in U.S.	13. Was Decedent of Hispanic O	rigin? (Specify Yes or No-	14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other treumatic event, the Medical Exact as finitely a conce.	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexica		Black, White, etc. Specify: PLACK
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Maryland	ould be fill Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last) William Glove	er .	18. Moth	alieline L	(Jacob)
Mary	d 2 shouth and N 7 is mail		19a. Informant's Name/Relationship (7)	(pe, Print) 19b.	Mailing Address (Street and Numb	ber or Rural Route Number	Sinds Town, State, Zip Code)
	permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 Burial 2 Cremation 3	cometer	Disposition (Name of y, crematory or other place)	Date	20c. Location - City or Town, State
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	/Medical Examiner		resulting in death)	Due to (or as a consequence			
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Box	death certific e attending pl id for use as t	Physician/Me	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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•	h		30. Name and address of person who o	ompleted cause of death (Item 23a)	(Type, Print)	/ / / /	MARCH 23, 2004 COTT (TY, MARY LAN)
- \$	Sta		31. Date filed (Month, Day, Year)	A A 32. Registrar's Signature		ANT ELLI	COTT (TY, MACY LAND)
	Regist	rar	MAR 3 0 2004	Denve B	sports		

DHMH 17 Rev 1/2001

		•	1 - For State of Maryland /	Depar <i>Certi</i>	tment o	of He	ealth a	ınd M	ental Hy	giene Reg. No	200	4 09789
N. C.	Physici	an	Decedent's Name (First, Middle, Last) Mary Jane Martin						2. Date of Dea	Da	y Year 2004	3. Time of Death 3:28 P
A	/Medic Examin	mercus	4a. Facility Name (If not institution, give street and number) Prince Georges County Medical	4	4b. City, To		ocation o		Haren	40	. County of Dea	
, k	Funeral Director	7	5. Social Security Number 272-20-8266 6. Sex 1 □ M 2★ F 7. Age (In yrs. last bite)		If Under 1 \ Months D		If Under a		8. Date of Birt (Month, Day Jul 7	h y, Year	9. Bit	thplace (State or Foreign ountry)
	the Maryland 28a-f show	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD Montgomery Silv 10e. Street and Number 10c. City 10e. Street and Number 10c. City 10e. Street and Number 10c. City 10e. Street 10c. City 10c. Ci	wn or Loca rer Sp		ode				10g. C	itizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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Baltimore,	Pages 1 ar ment of Heal ant: If item? ury or other		20a. Method of Disposition 1 Burial 2 Scremation 3 Removal from State	of Disposit tery, crema		of er place,)	C	Mar 27 2004	20c. L	ocation · City of	Town, Stete
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Vita		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☐ Inpatient 2 ☒ ER/C	Outpatient	3□ DOA	Other			n <i>(Check only o</i> me 5 ☐ Besid		6 □Other (Spe	acify)
Division of Vital Records,	ding h. After fune	Certification: T	27. Manner of Death 1 Natural	Time of Injury	28c		-	No	28d. Describe I	now inji	ury occurred	
DIV	i ji te e	Certifi	4 Homicide determined 256. Place of Injury 1 Killothia, building, etc. (Specify)						City or Tov	vn, Sta	te)	lural Route Number,
4	To the Hospital within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death of and/or inve	astigation, in	my opi	e, date an inion, dea number	d place, the occurr	and due to the	date ar	s) and manner and place, and du ate signed (Mon	e to the cause(s)
	S S S S S S S S S S S S S S S S S S S	-	Duncander re und		9		182	رح			-	-6 2004
	N		Paul A. DE Vure Ind 4203 Qy	eens	rint) Sorey	(20)	th	at	rsuille	· N	40 207	81
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 3 0 2004 32. Registrar's Signature	self!								

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 26, Jr. March 2004 10:10 P M Samuel Lewis Morgan, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Woodside Nursing Center Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year Aug. 3, 19 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F North Carolina Yrs Ĭ911 92 578-50-8602 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Exercit as man be redified at 1 ☐ Yes 2 No Washington D.C. N/A N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20015-1932 5222 42nd ST. NW United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if Item 27 is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Minister Religious Teaching 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be Samue1 Lewis Morgan Sr. Isabel Robeson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ina Morgan / Wife 5222 42nd St. NW; Washington D.C. 20015-1932 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot April 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Beltsville, MD * 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 22. Name and Address of Facility. Rapp Funeral and Cremation Services M00382 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Bo wel arge 4 week /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician Physiclan/Medical thet use as I IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ó in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown One Should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 28€ No 1 ☐ Yes 2 No 1 ☐ Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Sering Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1) SNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical mpletely and manner stated 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D38262 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANDHIKA 2401 eseguen 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 0 2004 Registrar

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

			1 - For State Registrar	State of Maryland	l / Departmen		Mental Hygien	•	09791
	Physici /Medic Examir	al	1. Decedent's Name (First, Middle, Last) WALTER V 4a. Facility Name (If not institution, give s	EWCOMER treet and number) AOSPITAL C		Town, or Location of Death	2. Date of Death Month Da MARCH A	ay Year	3. Time of Death 12; 26PM
	Funeral Director		5. Social Security Number 6. Sex		st birthday) If Under Months	1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year Feb. 13, 190	9. Birthplac	ce (State or Foreign
	ith the Maryland or 28e-f show	Director	10a. State 10b. County MD Baltime 10e. Street and Number		Town or Location eisterstow 10f. Zip		10g. C	10d	d. Inside City Limits 1 ☐ Yes 2X No y?
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28e-f show the Madical Evancher must be notified at	by Funeral [339 Walgrove Road 11. Marital Status 1 □ Never Married 2 □ Married 3\text{Wildowed 4 □ Divorced}	12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:	13. Was Deced	21136 dent of Hispanic Origin? (S city Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	IJSA 14. Race - American Black, White, etc Specify: White	
Maryland 21215-0036	D 5 5 5	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Decedent's Usua (Give kind of wo life. DO NOT us Sales Ma	rk done during most of wor se retired) nager	king	Kind of Business/Indus	stry
laryland	ss 1 and 2 should be filed. I Health and Mental Hygitem 27 is marked other. other traumatic event.	To Be	17. Father's Name (First, Middle, Last) William Newcomer 19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailing Address	18. Mother's Nan E11a B.			ode)
Baltimore, N	W ~ ====		David E. Newcomer 20a. Method of Disposition 1 \(\mathbb{M} \) Burial 2 \(\subseteq \) Cremation 3 \(\mathbb{R} \) 4 \(\subseteq \) Donation 5 \(\subseteq \) Other (Specify)	emoval from State	113 Dorga ace of Disposition (Nam metery, crematory or o tain View			MD 21117 ocation - City or Town	n, State
Balt	permit. Pag Department Important: i any injury o once.		21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Eline	Funeral Home		own, MD 21	L136 Approximate Interval Between
3.	Physician /Medical Examiner	Ů,	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque				0	Onset and Death
8760,	ate be executed hysician and the burial-transit	licai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque					
.O. Box 68	The law requires that the death certificate I tte has been signed by the attending physionage 2 should be detached for use as the t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	death 3 □Ectopic pr			23d. Date of delivery Month Da	
ords, P	w requires that been signed t should be deta	þ	Part II. Other significant conditions con CONGESTIVE IHYPERTROPHIC	HEART FAI	LURE		1 ☐ Yes 2		oly 4. Ynknown
of Vital Records,		Be Completed	CHRONIC REN 25. Was case referred to medical examiner?		28.	26. Place of Dea	24a. Was an autopsy performed? 1 Yes 2 2 Note the (Check only one)	prior to comp death?	y findings available pletion of cause of
Division of V	ding Phys h. After this funeral dii	6	1 Yes 2 No 27 Manper of Death 1 Natural 5 Pending 2 Accident investigation		R/Outpatient 3 DC 28b. Time of Injury M	OA Other: 4 \(\sum \) Nursing H 18c. Injury at Work? 1 \(\sum \) Yes 2 \(\sum \) No	ome 5 Residence 28d. Describe how inju		
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	al Certification:	3 Suicide 4 Homicide 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At hom building, etc. (Specify)	ledge, death occurred	at the time, date and place	28f. Location (Street a. City or Town, State	e) s) and manner as state	ed.
)	To the Ho within 24 To the Fu completel	Medical	(Check only 2 Medical Examinate) 29b. Signature and this of certifier	ner: On the basis of examination and manner stated.		in my opinion, death occu		ate signed (Month, Da	
	かか		30. Name and address of person who co	LI M HA	IRISH a	VORTHWES	7 HOSPI COURT	TAL CE ROAD M	
	Sta Registi		MAR 3 0 2004	22. Registrar's Signatu	4 Some	/2/			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 23 Day 2004^{ear} 4:20 Рм **Physician** Annette R. Neubauer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Greater Baltimore Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Feb. 6, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2X F Feb. Ohio 506-24-3954 83 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene.
Item 22 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exert nor must be notified at other traumatic event, the Medical Exert nor must be notified at 1 ☐ Yes 2 No Maryland Directo Worcester Ocean Pines 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26 Teal Circle 21811 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. t ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2X No Maryland 21215-0036 White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas L. Rowe Meta Czarnke ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 Teal Circle Ocean Pines, Maryland 21811
a of Disposition (Name of Date Date 20c. Location - City or Town Robert Neubauer (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite eny injury or of once. 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lorgaine Park Cemetery 3-26-2004 Woodlawn, Maryland 22 Name and Address of Facility
Witzke Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue Catonsville, Maryland 21228 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, ox complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Jepsis **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner nenmoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ut as a consequence of) or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): physician ar s the burial-t Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 ☐ Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 20 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1, Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Diractor: A completely filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ** Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Cynthus Sovicerus MS BS 5905659 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cynthia Sociano MA 32. Registrar's Senature 31. Date filed (Month, Day, Year) Registrar

			For State Registrar	State of Marylar	nd / Depa	artmer	nt of H	ealth a Death			Reg. No.	2001	3. Time of	
	Physicia /Medic		1. Decedent's Name (First, Middle, Las Mary Jane 0	Connell		-			1	Month March	Day 27	200	4 4:40	
	Examin		4a. Facility Name (If not institution, given Joseph Richey Hou 5. Social Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Security Number 6. Second Second Security Number 6. Second Security Number 6. Second Second Security Number 6. Second Second Second Security Number 6. Second Sec	ise	last hirthday	Ва	, Town, or Ltimo r 1 Year	re If Under 2		8. Date of Bin	th	County of De	A irthplace (State o	r Foreign
	Funeral Director		214-14-3953 Usual Residence of Decedent	□M 2Ø(F 85	Yrs.	Months	Days	Hours	Min.	(Month, Da 06/15/:	v. Year)		IL	
	a-fehow	ctor	MD Baltimon		ty, Town or Lo		Le						10d. Inside Cit	
;	in with the	al Director	10e. Street and Number 417 Locust Drive			10f. Zi	p Code	21228			10g. Citi:	zen of What	Country?	
950	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified a once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	I.S. 13.	Was Dece If Yes, spe 1 \(\text{Yes} \)		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	-	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. Whit	e
21215-0036	within 72 hounder.	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	edent's Usi e kind of w DO NOT	ork done d use retired	luring most)	of workin	g	16b. Ki	of Busines		
Maryland 2	uld be filed v fental Hygie rked othar tic event.	To Be Co	12 17. Father's Name (First, Middle, Last) Oscar M. Peters	4		nome	llakei	18. Mothe		(First, Middle,		Sumame)	ome	
Mary	nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (7) Michael O'Connell			ing Addres				Route Number			, Zip Code)	
Baltimore,	Pages 1 a ent of Hes nt: If item ry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disp cemetery, cre w Cath	osition (Na ematory or	me of other plac	θ)		/2004		cation · City	or Town, State	
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service Licen		5 t	22. Name a	nd Addres		Schw	ab Fund Baltimo	eral	Home,	Inc.	
18	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	a car			g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Beh Onset and I	ween
	be executed ician and purial-transit	Examiner	Sequentially list conditions, Tay, reading to an additional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons.a. c. Due to (or as a consec										
	death certificate e attending phys ed for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	al death 3	□Ectopic □ Other (s						23d. Date of c Month		Year
۵.	es be	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying	cause givi	en in Part I.			obacco u Yes 2[to the cause of d	
Vital Records,	The law ate has b page 2 s	Completed								24a. Was auto perfo 1 🗆 Yes		24b. Were prior to death	autopsy findings o completion of c ? es 2 No	available ause of
of Vita	Phyaician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	Hospital: 1 ☐ Inpatient 2 ☐	1			er: 4□ Nu	rsing Hon	(Check only one 5 Resi	dence		pecify) Has	pice
Division o	or Attending after death. Director: After in by the fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		28b. Time Injury nome, farm, s	М		/at k? Yes 2 ☐1	No	28f. Location (City or To	Street an	d Number or	Rural Route Num	nber,
	24 hours a Funaral D	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kn niner: On the basis of examin and manner stated.	nowledge, dea nation and/or i	ath occurre investigation	d at the tinen, in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) date and	and manner I place, and c	as stated. tue to the cause(s	5)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier			2	9c. Licens	e number	0				onth, Day, Year)	
	St	ate	30. Name and address of person who	completed cause of death (Ite	838 1	e, Print)	daw	57	Be	Himor	e p	1D 21	201	

Expires 4:40 PM Mar 29,2004.

& MARY O'CONNELL

RP	D		For State Registrar	State of I	Maryland .		rtment of tificate o			lental Hy	giene Reg. No.	2004	09794
	Physici		Decedent's Name (First, Middle, Last) Francis Carroll	O'Brien	ı					2. Date of Dea	ath	2004 ^{Year}	3. Time of Death 0434 A M
	/Medic Examin		4a. Facility Name (If not institution, give s St. Agnes Hospital	treet and numb			4b. City, Town Baltin		ation of Death		4c.	County of Death	A
	Funeral Director		216-34-5082	(M 2□F	Age (In yrs. last	birthday) Yrs.	If Under 1 Ye Months Day		Inder 24 Hrs. burs Min.	8. Date of Birt (Month, Da 10/02/	y, Year)	Cour	place (State or Foreign htry) MD
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimo	re	10c. City, T		cation sville					1	0d. Inside City Limits 1 ☐ Yes 2 ☑No
	h with the 3a or 28a	ai Dìrec	10e. Street and Number 210 Hilton Ave.				10f. Zip Code	228			10g. Citi	zen of What Cour	ntry?
36	rs after deat I', or itame 2 Xamener mu	by Funeral Director		12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ☑No		Vas Decedent of Yes, specify C		ic Origin? (Sp exican, Puerto ecify:	ecify Yes or No Rican, etc.)	-	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other then "natural", or itame 23s or 28s-1 show other traumatic event, the Madical Exameratic rules for publical at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	(Give life. [ent's Usual Ockind of work do	ne during ired)			Soci	nd of Business/Inc Lal Secur Lnistrat	dustry
land 2	uld be filed Mental Hygi irked other itic event.	To Be Co	17. Father's Name (First, Middle, Last) James Shannon O'Bi		, 0	ompac		18.	Mother's Nam	e (First, Middle,	Maiden		
Mary	nd 2 shoulth and N 27 ie ma	•	19a. Informant's Name/Relationship (Ty Kathy O'Brien/Wife				•			imore, N		r Town, State, Zip L 228	(Code)
nore,	Pages 1 a nent of Hea ant: if Item ary or otha		20a. Method of Disposition 1 Burial, 20 Cremation 3 1 4 Donation 3 Dother (Specify)	N	ate New		sition (Name of natory or other)		03/29	/2004		cation - City or To	
Baltii	permit. Pages Department of temportant: if the eny injury or of anges.		21. Signature of Furtural vervice violens	A-/		22 3 t	Name and Ad	dress of Asht	Facility Sch	wab Fun	eral	Home, 1	Inc.
3	Physician /Medical		23a. Part : Enter the disease, or conformation shock, or heart failure. Est only or immediate Cause (Final disease or condition resulting in death)	Re cause on each	sture as a consequen	abo		^		or respiratory a		ım	Approximate Interval Between Onset and Death
8760,	icate be executed physician and sthe burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	·	as a consequent								
.O. Box 687	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1☐Live birt	ome of pregnancy h 2 Fetal de nt at time of deat m	eath 3	Ectopic pregna Other (specify					23d. Date of delive Month	ery Day Year
s, D	requires that t een signed by hould be detad	by	Part II. Other significant conditions con	ntributing to dea	th but not resulting	ng in the ur	nderlying cause	given in	Part I.	23e. Did t		se contribute to the	he cause of death? pably 4 Unknown
Vital Record	The farate has	Completed								24a. Was autor perio		prior to co- death?	psy findings available mpletion of cause of 2 \(\sum \) No
Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 □ No	lospital:	patient 2 EF	VOutpatien	t 3[XDOA	Other		h <i>(Check only c</i> ome 5 ☐ Resi		6 □Other (Specif	(v)
ion of	ding After fune		27. Manner of Death 12 Natural 2 Accident 5 Pending investigation	28a. Date of		Bb. Time of Injury	28c. l	njury at Work?	2 🗆 No	28d. Describe	~		,,
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	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Phy (Check only one)		is of examination								
N.	1	Me	29b. Signature and little of certifier	In/	M			ense nur .C.M				te signed <i>(Month,</i> ch 25, 20	
	V		30. Name and address of person who co	ompleted sause	of death (Item 2	3a) (Type,	Print) L11 Peni	n St	reet, E	Baltimon	œ, N	Maryland	21201
	St Regist	ate rar	31. Date filed (Mostly Ray, 30ar) 20		gistrar's Signatu	9	selle)						

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment <i>rtificate</i>			and M	lental Hy	giene	20	04	0979	5
	Physici		1. Decedent's Name (First, Middle, Las						_	2. Date of De Month MA-2CH	Da		Year 2004	3. Time of Death 20:45	
	/Medic Examin		Clarence Benjamin 4a. Facility Name (If not institution, give			4b. City, To	own, or	Location of	of Death	11/11/2001			of Death	20.13	
	aaiiiii		ST. AGNES HOS	PITAL		BA	MI	MO	RE				N/A		
	Funeral Director		213-16-7543	X 7. Age XM 2 F	(In yrs. last birthday) 82 Yrs.		Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, Di Nov • 1	rth ay, Ye <i>ar)</i> 5 , 1	921	Coun	lace (State or Forei try) yland	ign
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation							10	0d. Inside City Limi	ts
	Mary Ff sh	tor	MD Baltim	ore		Balti	more	2						1 ☐ Yes Man	10
	th the	Funeral Director	10e. Street and Number			10f. Zip C	ode				10g. Ci	tizen of \	What Coun	try?	_
	ath wi	rai	5422 Highridge Str					L227				nite	d Sta	tes	
	er de	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E- Armed Forces? 1 ☑Yes 2 ☐ No	ver in U.S. 13.	Was Deceder If Yes, specify	nt of His y Cubar	spanic Ori n, Mexican	gin? (Spo 1, Puerto	ecify Yes or No Rican, etc.)	D-		ce - America ck, White, e		
920	urs aft	ρ	3 ∑Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 25	X No	Specify:				Specify	y:	White	
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Maryland	ges 1 and 2 should nt of Health and Mer i if item 27 is marks or other traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (S	Street a	nd Numbe	or Rura	al Route Numb	er, City	or Town,	State, Zip	Code)	
	of Health item 27 other tr			aughter	1209 20b. Place of Dispo	-		enue		butus,		·			
Baltimore,	permit. Pages 1 Department of F important: If ite any injury or ot		20a. Method of Disposition 1 🕅 Burial 2 🗆 Cremation 3 🗆		Crestlaw	matory or other n Memo:	er place	1					- City or To		
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Ba	Depariment Department of the police of the p	(delletine) 4	ATTING F	1 1/1 1/20/11					Rd.,					
	Physician /Medical Examiner	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as a Due to (or as a c.	STATIC consequence of):	^				AN C			E	Approximate Interval Between Onset and Death VAVAS	
68760,	tificate be executed og physicien and as the burial-transit	ical	resulting in death) Last	Due to (or as a	consequence of);										
.O. Box	that the death certifica ed by the attending pr detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetal death 3	Ectopic preg							te of deliver anth I	ry Day Year	
rds, P	sign d be	by	Part II. Other significant conditions or	ntributing to death but	not resulting in the u	nderlying cau	ise givei	n in Part I.		23e. Did 1		use cont		e cause of death? ably 4 □Unknow	'n
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	To the To the Comp	Σ	29b. Signature and title of certifier			29c. L	0	number	-		29d. Da	te signe	d (Month, E	Day, Year)	
	1		Man	- Du	7		41	669	3	I	MAR	CH	27	2004	
	10		30. Name and address of person who o	_	ath (Item 23a) (Type,	Print)	TAZ	_	400 KA	JIVOOR	TUN	$M_{\rm C}$	NEV	UE 279	
	Sta Registr		31. Date filed (Month Day, Year)	32. registrar	's Signature	Sant			N. C.	C. 1. VO/C		1000	,		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mont Floyd Ray Oliver 2004 March 26 1:10 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Rosedale Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dev. Year) 12/31/1932 9. Birthplece (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funeral** Days 1**⋈**M 2□ F 225-36-8627 71 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Director Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1513 ODell Avenue 21237 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Mechanic Leasing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h Lester E. Oliver Edna V. Keyton 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geneva K. Oliver - Wife 1513 ODell Avenue Rosedale, Maryland 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges
Department of
Important: If it
eny injury or o 1 ■ Buriat 2 □ Cremation 3 □ Removal from State * 4 □ Donetion 5 □ Other (Specify) Mt. Olivet McGagysville, Virginia 21. Signature of Funeral Service Licenses David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Concer **Physician** zyn /Medical **Examiner** Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Box 68760, Geath certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 4 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificete 1 ☐ Yes 2 ☐ No 1 Yes 2 -No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 3 NO erat Director: After this filled in by the funeral dir 27, Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) luce un 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 1120 Rolling Road, Baltimore, Maryland 21228 Dr. Kenneth Williams, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 0 2004 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of L	Death	Re	g. No. 20	04 09797
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Dete of Deet Month	Day	Year 3. Time of Death
1	/Medica	_	JOHN W. O'BRIEN			MARCH	23	04 330 AM
1	Examine	r	4e Fecility Neme (If not institution, give street end number)	1	Ib. City, Town, or Loc APERDEE		4c. County o	KFORD
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthd			8 Date of Birth		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd 7. Age (In yrs. last birthd 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthd) 7. Age (In yrs. last birthd)	Months Days	Hours Min.	Month, Day, 2-24	Yeer) - 29 /	9. Birthplace (State or Foreign Country) ENNSYLV ANIA
	and sand	ł	10a. Stete 10b. County 10c. City, Town of	r Location				10d. Inside City Limits
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	1 the	8	10e. Street end Number	10f. Zip Code		1	g. Citizen of W	hat Country?
	h with	<u>a</u>	21 LIBEATY ST	210	DI		USA	
0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23s or 28s-f show wit, the Medical Examiner must be routfied at	Funeral Director		 Was Decedent of Hi If Yes, specify Cuba Yes 2 No 		cify Yes or No- Rican, etc.)	Black	- American Indian, k, White, etc. white
8	al', o	2	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Detes:	To res 240 No	Specify:		Specify:	WILLE
21215-0020	72 hc	Completed	(Specify only highest grade completed) (G	ecedent's Usual Occupa	during most of workir		16b. Kind of Bus	siness/Industry unk
121	ithin	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired	0			
	filed with Hygiene. rther than	ဦ ပ	unk unk	.1	18. Mother's Name	/First Middle A	Aaidon Surname)1_
and	to be fill	B	17. Fether's Neme (First, Middle, Lest)	unk	10. Mother 5 Hame	(1 Irai, Imaare, I	aloen oumanie	unk unk
Maryland	2 she end is m	0	19a. Informant's Name/Relationship (Type, Print) 19b. M	failing Address (Street	and Number or Rure	l Route Number	City or Town, S	State, Zip Code) unk
	of Health item 27	- }	Bernard Yukna/DME	isposition (Name of		Date	20a Location - (City or Town, State
Baltimore,	B 0 - 5			crematory or other place	ce)	Date	EOO. EOOdilon	ony or rount, outlo
Balt	permit. Peg Depertment importent: I any Injury o			22. Name and Address State Anata Baltimore,	omy Board	_	Baltimo	ore Street
		\dashv	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dyin	ng, such as cardiac o		est,	Approximate Interval Between
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in deeth) e. MYOCARD/I Due to (or as a condition resulting in deeth)	AL IN F	ACTION	1	· P	Onset and Death
68760,	law requires that the death cartificate be assecuted as been signed by the attending physician end 2 should be detached for use as the burial-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a con injury that initiated events the condition of th	nsequence of):	iedy (v rige	yayı	NI EXS	
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Box	ath cattern	lan						
o.	the shed	ysic	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause giv	en in Part I.	.,		tribute to the cause of death?
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of Vital Records,	v requiras that the daath car been signed by the attendin should be detached for use	Completed by Physician/				24a. Wes a perform		24b. Were autopsy findings available prior to completion of cause of death?
Be	has ga 2	Ĕ				10 Y	s 2 No	1 ☐ Yes 2 No
ta	n: Ti		25. Was case referred to medical		26. Place of Death	(Check only on	-	
5	s cert	To Be	examiner?	atient 3 DOA Oth				er (Specify)
	g Phy er this ieral c	ä	27. Menner of Death 28a. Date of Injury (Month, Dey Year) Inju		yet 2	28d. Describe h	w injury occurre	ed
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	To the Hospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, paga:	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do 2 Medical Examiner: On the basis of examination and/o and manner stated.	leeth occurred at the tin or investigation, in my o	me, date and place, a pinion, death occurre	and due to the c ed et the time, d	ause(s) and mar ate and place, a	nner as stated. and due to the cause(s)
	vithin Fo the	¥	29b. Signature end title of certifier	29c. Licens				(Month, Dey, Yeer)
	F>F0		Roma C. V. Se MA nouse	Do	014206		March >	23 20n4
			30. Name end address of person who completed cause of death (Item 23a) (T)	/pe, Print) A	LARINA	IVE D	11/10	13 2004 14 21222
	-01-		31. Date filed (Month, Day, Year) 32 Registrar's Signature	,	MINITED X	r 5 /3	14210 1	9 =12 -2
	Stat		MAR 3 0 2004	mark)				

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Please Type or Print in Black Indelible Ink. Ensu	re All Copies Are Legible.	
State of Maryland / Department of Health a Certificate of Death	and Mental Hygiene 2004	09798
irst, Middle, Last) Matthew Painter, Jr.	2. Date of Death Month March 25, 2004	3. Time of Death

4c. County of Death

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1242 Circle Drive Batto, ML

29d. Date signed (Month, Day, Year)

March 25, 2004

1 ☐ Yes 2 ☐ No

4b. City, Town, or Location of Death

Baltimore

Physician /Medical 4a. Fecility Name (If not institution, give street and number) Examiner

Director

Completed by Funeral

Be

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1. Decedent's Name (First, Midd

St. Agnes Hospital

Adrian

Funeral

Director with the Maryland or 28a-f show traumatic event, the Medical Examiner plust be notified at Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant 1 ferms 27 is marked other than "natural", or Items 23 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai

Baltimore, Maryland 21215-0036

Physician /Medical Examiner Examiner

The law requires that the death certificate be executed attending physicien and for use as the burial-transit been signed by the s should be detached page 2; has or Attending Physician: filled in by the funeral director, within 24 hours after death. To the Funeral Director: After

Physiclan/Medical

Completed by

Be

2

Certification:

P.O. Box 68760.

Division of Vital Records,

To the Hospital

Medical 29b. Signature and title 30. Name and address 31. Date filed MARP 3. War 2004 State Registrar

3 ☐ Suicide

29a. Certifier

4 Homicide

8. Date of Birth (Month, Day, DEC 10, 5 Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1∑M 2□F South Carolina 51 1952 228-66-4396 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location Maryland Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1242 Circle Drive 21227 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 TNo If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Federal Government 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Adrian Matthew Painter, Sr. Georgia Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristina E. Painter/Wife 1242 Circle Drive Halethor; e, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3-27-04 Baltimore, MD 21. Signature of Fareral Service Licens Edward A. Gr ²² Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD Edward A. Gregorchik 299 Frederick Road Baltim

23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a. Two gushort

Due to (of as a consequence of): resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1X Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient XX DOA 1X Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Deceased shot by 3-24-04 1 ☐ Yes 2 No 11:26AM 2 Accident

of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

6 ☐ Could not be

determined

32. Registrar's Signature

yard of

houl

29c. License number

O.C.M.E.

1 Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

22 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Front

CPM 04-02153 Dora Pugh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	- State Unpend Item #	State of 23a&27 per n	Maryland / ne G830 4/1	Depa 6/84 i	rtment of H	ealth and Death			2004	
Physician /Medical	1	Decedent's Name (First, Middle		Lee Pugl	h			2. Date of D Month March	Day	Year 2004	3. Time of Death 14:28
Examiner		la. Facility Name (If not institution) 47 Gravelo Ci		ber)			ale Riv	er			timore
Funeral Director		218-80-1445	6. Sex 1 □ M 2√2 F	Age (In yrs. last	Vrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. (Month, D	irth ay, Yea <i>r)</i> 3 1,1 9	9. Birthp Cour 61 Mary	place (State or Foreign ortry) yland
-f show		Usual Residence of Decedent 10a. State 10b. County MD Balt	imore	10c. City, To	own or Loc		ddle F	River			10d. Inside City Limits 1 ☐ Yes 2X No
2 Stoud be lied within 72 hous arier bear with the maryana. Is marked other than "natural", or Itema 23a or 28a-f show sumatic event. It a Madical Evaninat must be notified at	2	10e. Street and Number 47 Gravelo	Circle			10f. Zip Code	220		10g. Citiz	en of What Coul	ntry?
al', or iteme 23a or 28a-f shov Examiner must be notified at the European Director	Dy ruileid	11. Marital Status 1 Never Mamed 2 Marri 3 Widowed 4 Divorced	12. Was Deced	2 ₹ №	If	Vas Decedent of His Yes, specify Cubar □ Yes 2√2 No	spanic Origin?	(Specify Yes or N erto Rican, etc.)	0- 1	4. Race - Americ Black, White, SpecifiWhit	etc.
ygiene. Ner than "natural", t. tra Medical Exp.		15. Decedent (Specify only highes Elementary/Secondary (0-12) 11th			(Give I life. E	lent's Usual Occupa kind of work done d DO NOT use retired, emaker	tion uring most of v	working		d of Business/In	dustry
and Mental Hygiene. Is marked other than sumatic event, it a Marked other than To Be Comp.	מ	17. Father's Name (First, Middle, Homer Housto		'				_{lame (First, Middle} a Pruit		Sumame)	
Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturany injury or other traumatic event. It a Mudical April 19.		19a. Informant's Name/Relationsl Keith Pugh 20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (S) 21. Signature of Funeral Service	3 □Removal from S	20b. Place	823 e of Dispos etery, crem view	g Address (Street a Feruson sition (Name of natory or other place Cremato: . Name and Addres	Road	Joppa M Date 1/04	1D 21 20c. Loc Balt	085 ation - City or To	own, State
	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (c	or as a consequen	ce of):	cotic cardio	ovascular	disease			
been signed by the attending t should be detached for use as	Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☼ Unknown	1 ☐ Live bi	come of pregnancy rth 2 □Fetal de ant at time of death wn	ath 3	Ectopic pregnancy Other (specify)			2	3d. Date of delive	ery Day Year
en signed b	2	Part II. Other significant condition	ons contributing to de	ath but not resultin	ig in the ur	nderlying cause give	n in Part I.		tobaccous Yes 2 🛣		he cause of death? pably 4 ∐Unknow
page 2 sho	Completed							per	s an opsy formed? 2 \(\square\) No	24b. Were auto prior to co death? 1 (2) Yes	psy findings availab impletion of cause o
within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2	Certification: 10 Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 X Natural 5 Pendin investights of Could investights of Could investights.	g 28a. Date of (Montiligation	of Injury 28 h, <i>Day Year)</i>	Outpatien b. Time of Injury	28c. Injury Work M 1 🗆 Y	at Nursin	Death (Check only g Home 5 ☐ Res 28d. Describe	sidence 6 how injury	occurred	
eral Direc		4 Homicide determ	ZOO. FIAU	of Injury - At home ig, etc. (Specify)			e, date and ni	City or To	own, State)		al Route Number,
within 24 hours after death. To the Funeral Director. After this certific, completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifyir Medical 29b. Signature and title of certifie	Examiner: On the ba and mann	sis of examination	and/or inv	vestigation, in my op	oinion, death o	ccurred at the time	, date and	place, and due to	o the cause(s)
7.		Jousha 3 30. Name and address of person	4			Print)	C.M.E			rch 29,	
State Registra		Tashu Z Give 31. Date filed (Month, Day, Year)	en bergi	ogistrar's Signature	111	Penn Stre	et, Ba	ltimore,	Mary.	land 212	201

			1 - For State Registrar	State of	Maryl		artment of H			giene Reg. No. 20	04	09801
			Decedent's Name (First, Middle, Last))					2. Date of De	ath		3. Time of Death
	Physici /Medic		Edwin Joseph Power	s					Month March	26, 200	Year 4	10:30 p M
	Examin		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City, Town, or	Location of Death		4c. County	of Death	
			Upper Chesapeake M				Bel A				rford	
	Funeral		5. Social Security Number 6. Se	x JM 2□F		rs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	y, Year)	Cour	place (State or Foreign
	Director		092-18-3616		78	113.			Nov. 1	, 1925	New	York
	laryland show		10a. State 10b. County		10c.	City, Town or Le	ocation				1	0d. Inside City Limits
	Many	to	Md. Harford			Ве	el Air					1 □Yes 2 □No X
2	vith the Man or 28e-1 sh be notified	lrec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	
0	23e c	alD	1305 Scottsdale Dr	rive, U	nit F		2101	.5		United	Stat	es
/3	hours after death with the Maryland turel', or Items 23e or 28e-f show al Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Dece Armed For		1 U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Rac Blac	e - Americ ck, White,	ean Indian, etc.
98	s afte	by Fu	1 ☐ Never Married 2 ☐XMarried 3 ☐ Widowed 4 ☐ Divorced	1X Yes If Yes, Giv	е		1 ☐ Yes 2√√ No	Specify:		Specif		white
30	hour ture		15. Decedent's Edu		ites WW I)	dent's Usual Occupa	ation		16b, Kind of B	usiness/Inc	dustor
5 25	within 72 ene. than "na ne Madic	plet	(Specify only highest grad Elementary/Secondary (0-12)	le completed)	Aor E . \	(Give	kind of work done of DO NOT use retired	furing most of work.	ing	100. 11410 01 0	001110001111	dustry
212	0 0 = -	Completed	Elementary/Secondary (0-12)	College (1	-401 3+)	chen	nist			federa	1 gov	ernment
p	be filed tal Hygi d othar evant, I	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Name	e (First, Middle,			
<u>a</u>	Men Men arke	2	Edward Joseph Powe	ers				Mary M	cCann Po	owers		
Maryland	O 0 = 6	i e	19a. Informant's Name/Relationship (T)	rpe, Print)			ng Address (Street a					,
200	s 1 and 3 f Health itam 27 othar tr		Mary E. Powers/wif	e	201		Scottsdal		Unit F			
00	00		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ F		State	cemetery, cre-	matory or other plac	9)		20c. Location -		
16 H	permit. Page Department o Important: If any injury or once.	,	 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 				tius Cem.	3/31		Forest		
(A)	permi Depa Impo any is		21. Signature of Furneral Service Licens			2	2. Name and Addres Schimunek					
W			23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that ca	aused the d	eath. Do not en	610 W. Ma	cPhail Ro	nad, Be	L Air, N	14. 2	1014 Approximate
	Dharaisiss		Immediate Cause (Final	ne cause on ea	ach line.	Yanı	Company of the Compan	RE				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a con:	sequence of):	THILL	IVC			-	MEEKS
- 1	Examiner			CHRO	NIC		SUCTIVE	PULME	YSIAMC	DISE	SE	
	7 -	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence of):						
	cate be executed oblysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c								
30,	oe execian a	Ě	resulting in death) Last	Due to (or as a cons	sequence of):						
9	the state	dical		d			-					
7/ 0x6	ding	/Me	IF FEMALE:	23c. If yes, outo	come of ore	onancy				oad Da	te of delive	
B	eath certific attending pl for use as I	Physician/Me	in the past 12 months?	1□Live bi	irth 2 ∐ F antattime o	etal death 3	Ectopic pregnancy Other (specify)			Mo		Day Year
5.0	at the de by the tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno						·		
S,	de de	y P	Part II. Other significant conditions co	01		resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use cont	ribute to th	e cause of death?
	w requires been sign should be	ed t	ISCHEMIC CA	NOO	MYO	PATHY	 		1 🗆 Y	′es 2□No	3 Prob	ably 4 Munknown
C'n ecord	law re	plet							24a. Was	an 24b. \	Vere autor	psy findings available appletion of cause of
-2 E	The taste has page	Completed by							autop perfor 1 ☐ Yes	med? 2 □ No 1	death?	2 No
Tr E	ician:] certifical ector, p	Be	25. Was case referred to medical examiner?					26. Place of Death	(Check only o	ne)		
1475	Physic this ce al dire	흔	1 ☐ Yes 2 ☑ No			ER/Outpatier		4 El Norsing Ho)
	ding Physician: h. After this certific funeral director,	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Monti	of Injury h, Day Year	28b. Time o Injury	Work		28d. Describe h	ow injury occurr	ed	
er S	uttandi death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	280 Place	of Injury - A	t home farm et	M 1 □ 1	′es 2□No	28f Location (S	Stroot and Numb	or or Pum	l Route Number,
3	ipitel or Att burs after d laral Diract filled in by	Certification;	4 Homicide determined	buildir	ng, etc. (Spi	ecify)	eet, factory, office		City or Tow	n, State)	ei oi nuiai	r noute reamber,
(40	Hos 24 h Fun fely	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the ner: On the ba and mann	sis of exam	knowledge, deat ination and/or in	h occurred at the tim vestigation, in my op	e, date and place, a inion, deeth occurr	and due to the ded at the time, o	cause(s) and ma date and place, a	nner as stand due to	ated. the cause(s)
	To tha within 2 To tha comple	Me	29b. Signature and title of certifier	1			29c. License	number	2	29d. Date signed	i (Month, L	Day, Year)
			> VN476.hu	fork	av	M	DZ!	DO2 +	٨	MRCH &	27,0	2004
	1401		30. Name and address of person who of	ANCAR	e of death	tem 23a) (Type,	Print) HAVEO	VUE B	EL 4	IR M	DZ	(0/4
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 0 2004	/32. Re	egistrar's Si	gnature	. ·					

			1 - For State Registrar	State of	Maryland / Depa Ce	artment of F <i>rtificate of</i> I	lealth and Death	Mental Hyg	iene 19. No. 200	4 09802
	Physic /Medi		Decedent's Name (First, Midde Carl		erry			2. Date of Deat Month MARCH		3. Time of Death
	Exami		4a. Facility Neme (If not institution GOOD SAMARITAN	on, give street and numb		4b. City, Town, or BALTIN	Location of Deat	h	4c. County of E	
	Funeral Director		5. Social Security Number 233–36–1051	6. Sex 7.	Age (In yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Sept. 6,		Birthplace (State or Foreign Country) WV
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County MD		10c. City, Town or Lo					10d. Inside City Limits 1 □ Yes 2 No
	h with the P 23a or 28a- at be notifi	ai Director	10e. Street and Number 5512 Mayview Av	N/A	Baltim	10f. Zip Code	206	10	Og. Citizen of What	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If tiern 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Madical Examinational be multiled at ance.	by Funerai	11. Marital Status 1 Never Married 2 X Mar 3 Widowed 4 Divorced	12. Was Deceder Armed Force 1 X Yes 2	es? □No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔯 No	spanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - A	mencan Indian, Thite, etc. White
121	d within 72 ho giene. or than "natur itte Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 12	nt's Education est grade completed) College (1-4 N/A	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of wor	king	6b. Kind of Busine	•
ryland ;	2 should be filed and Mental Hygin is marked other sumatic event,	To Be C	17. Father's Name (First, Middle, Tolbert Perr	Last)			Alma Ru	ne (First, Middle, M th Baldwi	laiden Sumame) Ln	
	1 and 2 sh Health and Iem 27 is n		19a. Informant's Name/Relations Christine Perry 20a. Method of Disposition			Mayview A	ve. Bal	timore, M	ID 21206	
Baltimore,	permit. Pages Department of Important: If it any injury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	Dulaney Va Memorial (alley Gardens	20	•	0c. Location - City Timonium	
Ba	Depa Impo any in		23a. Part 1. Enter the disease of	Michael J	I. Flagle	Name and Addres Lemmon Fur 10 W. Pad	neral Ho onia Roa	d Timoni	11m. MD 2	1093
	nysician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Antevo.	i iine.	liovascular			st,	Approximate Interval Between Onset and Death
3	physician and sthe burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a consequence of):					
	in the law requires that the beath bettings to have been signed by the attending phy bage 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of o	eliv <i>e</i> ry Day Year
rds, r	been signed I	by	Part II. Other significant condition	ons contributing to death	n but not resulting in the un	derlying cause giver	n in Part I.			to the cause of death?
		e Completed	25. Was case referred to medical					24a. Was an autopsy performe	prior to	
DIVISION OF VI	this cer al direct	ToB	examiner? 1X Yes 2 No 27. Manner of Death 1 XiNatural 5 Pendin 2 Accident investig	Hospital: 1 Inpa 28a. Date of In (Month, D	njury 28b. Time of	3 DOA Other 28c. Injury a Work?	4 Nursing Ho	me 5 Residence 28d. Describe how		ecify)
	ours after de eral Direct filled in by t	i Certification;	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of I building,	njury - At home, farm, streetc. (Specify)			City or Town, S	State)	Rural Route Number,
400	ithin 24 ho o the Fun ompletely I	Medical	(Check only one) 2 Medical I	and manner	st of my knowledge, death of examination and/or investated.	occurred at the time estigation, in my opin 29c. License	nion, death occurr	ed at the time, date	se(s) and manner a and place, and du . Date signed (Mor	e to the cause(s)
,	χ\		30. Name and address of person of	M. TH	death (Item 23a) (Type P	0.0	C.M.E.		ARCH 27,2	
	Stat Registra	te	JACK M. TTT 31. Date filed (Month, Day, Year) MAR 3 0 200	71 M.D. 32. Regis	trar's Signature	11 Penn S	Street, I	Baltimore	, Marylar	od 21201

			For Stata Registrer	State of	Maryland .		artment of H tificate of		ınd Men		0 S.on.	04	09803
			Decedent's Name (First, Middle, La			,				Date of Death	Day	Year	3. Time of Death
	Physici: /Medic	al	Edward			ent	-			Tarch	20 2	1004	8:07PM
e.	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o				4c. County		- 5
			5. Social Security Number 6.5		Age (In yrs. last	t hirthday)	Comb If Under 1 Year		24 Hrs. a r	Date of Birth	Alle		place (State or Foreign
Н	Funeral Director			M 2□F	56	Yrs.	Months Days	Hours	Min. Au	Month 1 Day,	1947	Mary	y Land
	ס		Usual Residence of Decedent										
	anylan show	_	10a. State 10b. County		10c. City, T								10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	ecto	MD Allega	ny 	Cu	mber.				10.	- 03:41	10 1 0 - 1	
	with ti	i o	10e. Street and Number 213 Virginia Ave:	0110			10f. Zip Code	502		100	g. Citizen of V US.		intry?
	leath ns 23	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S.	13. \	Was Decedent of H		in? (Specify	Yes or No-			ican Indian,
936	be tiled within 72 hours after death with the Maryland ital Hygiene. Ind other than "naturel", or Items 23a or 28a-f show event, I're Medical Examination must be motilled at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	Ž(No		f Yes, specify Cub 1 ☐ Yes 2 🛣 No		, Puerto Rica	n, etc.)		k, White www.white	
2-0	72 ho	sted	15. Decedent's E (Specify only highest gr		1	6a. Deced	dent's Usual Occup kind of work done	ation	of working	16	6b. Kind of Bu	siness/lr	ndustry
7	ithin dithin	Completed by	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. I	DO NOT use retire	d)			+		ation
7	iled w Hygier Iber ti	CO	8 17. Father's Name (First, Middle, Last	0			taxi dri		r's Name /Fir	st, Middle, Ma	transp		461011
and	d be f antal h	o Be	Charles Frankl		r					e Mello		,0)	
Ž	shoul nd Me mark mati	2	19a. Informant's Name/Relationship			19b. Mailir	ng Address (Street	and Numbe	r or Rural Ro	ute Number, (City or Town,	State, Zi	p Code)
Z	nd 2 aith a 27 is		Annamarie Lannon	/daughter		29 E	. Harriso	on Str	eet Pi	edmont	, WV 2	6750	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Exam our mast be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☒ Donation 5 ☐ Other (Speci		com	e of Dispo etery, cren	sition (Name of natory or other pla	сө)	Date	20	Oc. Location -	City or T	own, State
Balt	permit. Departr Importe any Inje		21. Sign thus of Funer I Service Lice ROTALO	Wady, Di	rector		Name and Address ate Anat 1timore,		5ard 65 21201	55 W. I	Baltimo	ore S	Street
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau	sed the death. I h line.	Do not ent	er the mode of dyi	ng, such as	cardiac or res	piratory arres	it,		Approximate Interval Between
	Prrysician		Immediate Cause (Final disease or condition	Co	nen of:	The	Colon-1	neton	tales				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequen	nce of):							,
В		-	Sequentially list conditions,	b. Due to (or	as a consequen	nce of):						-	
Т	uted I Insit	mlne	if any, leading to immediate Cause (Disease or injury										
Ċ,	cate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequen	nce of):							
8760,	ite be iysicie ne bur	dicai		_ d									
9	ntifica ing ph	Med	IF FEMALE:								-1-		
Вох	death certificate be executed e attending physicien and nd for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?		n 2 ☐ Fetel de	eath 3□	Ectopic pregnanc	у			23d. Dat	e of deliv	rery Day Year
0	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	t at time of deatl n	h 5∟	Other (specify) _						
<u>α</u>	requires that the delen signed by the hould be detached	/ Ph	Part II. Other significant conditions	contributing to deal	h but not resultir	ng in the u	nderlying cause giv	en in Part I.		23e. Did toba	cco use conti	ribute to 1	the cause of death?
ds,	uires n sign	d by								1 ☐ Yes	2 10 No	3 🗆 Pro	bably 4 Unknown
Records,	> 0 0	Completed								24a. Was an	24b. \	Vere aut	opsy findings available
Re	0 - 0	omb								autopsy performe 1 □ Yes 2 □	ed?	leath?	ompletion of cause of
Vital	icien: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place		eck only one)			A Land 110
of V	S S S	To	examiner? 1 ☐ Yes 2 ☐ N o	Hospital: 1 Inp		VOutpatien	t 3 DOA Ott	ner: 4 🗆 Nur	rsing Home	5 Residen	ce 6 □Oth	er (Speci	fy)
D L	ing Ph	on:	27. Manner of Death 1 → Natural 5 → Pending	28a. Date of (Month,	njury 28 Day Year) 28	Bb. Time of Injury	Wo	rk?		Describe how	injury occurr	ed	
sio	Attending r death. sctor: After	icati	2 Accident investigation 3 Suicide 6 Could not to	99 Place of	Injury . At home	torm at		Yes 2 1		ocation (Stro	not and Alumb	or or Dur	al Route Number,
Division	5 th 6	Certification;	4 ☐ Homicide determined	building	, etc. (Specify)	e, iaim, sii	eet, factory, office			City or Town,		er or Hur	ar moute (vulliper,
	ot 4 project	edical C		hysicien: To the be miner: On the bas and manne	s of examination								
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. Licens	se number		290	d. Date signed	(Month,	Day, Year)
			> Allen	mo,			DO	01756	5	7.	nanch	20.	2004
			30. Name and address of person who	completed cause	of death (Item 23 トン 人 とっ	За) (Туре, + і Н	Print)	Vzle	171 2	1502			
	Sta Registi		/- J Bollino J- 31. Date filed (Month, Day, Year) MAR 3 0 2004	32. Reg	istrar's Signatur	Las	160						
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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** REYNOLDS 18:35 M MARCH JOHN 28 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A THE HOPKINS CITY JOHNS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 8, 9. Birthplece (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min 1 □ xM 2 □ F 136-32-8775 61 1942 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event. Its Madical Examinar must be notified at 1 ☐ Yes 2 No Funeral Director California Mendocino Albion 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 33402 Albion Ridge Road 95410 **USA** 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Operations Hi-Tech Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of John Reynolds Dorothy Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 in DeAnna Reynolds/Wife 33402 Albion Ridge Road Albion, CA 95410 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō 9 permit. Page Department of Important: If any injury or Metro Crematory Inc. 3-29-04 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of 299 Frederick Road MD. Inc. Baltimore, MD Thomas Gregor 21228 23a. Pert1. Enter the disease, or complications in caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** B CELL LYMPHONA DIFFUSE LARGE 6 HONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the atte 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 225No 1 Yes 2 X No To the Hospital or Attending Physicien: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation filled in by the 3 🖺 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier, RES-000 MARCH 28, 2004 MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JAMES KIN, THE JOHNS HOPKINS HOSPITAL, 600 NOISTH WELFE STREET, BALTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year)
MAR 3 0 2004 32. Registrar's Signature State doub! Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1 - State Registrar	Olate of W	laryland / Depa <i>Ce</i>	rtificate of			No. 2001	1 0980
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dical	4 = 10, 41 44)	4h City Town o	r Location of Death	arcii .	4c. County of Dea	
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	Vantage House 5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthday)	Colum If Under 1 Year		Date of Righ	Howard	
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	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Lim
7		1						1 ☐ Yes 2√0x
Director	Maryland Howa	ra	Co.	lumbia				10.00
100	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	ountry?
-B	5400 Vantage	Point Road		2104	4		U.S.A.	
Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13.	Was Decedent of H	tispanic Origin? (Specify an, Mexican, Puerto Ric	Yes or No-	14. Race - Ame	ncan Indian,
		ied 1 ☐ Yes 2亿	No			an, etc.)	Black, Whit	e, etc.
þ		If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Specity:	White
ed	15. Deceden	t's Education	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business	Industry
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Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Engineer		A	Engineers	
ŭ	17. Father's Name (First, Middle,	Last)	OTVII	Tugrucer	18. Mother's Name (F	irst Middle Ma		
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ဥ					Amelia vor			
	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mailin	ng Address (Street	and Number or Rural R	oute Number, C	ity or Town, State, 2	Zip Code)
	Margery Ramire	z (Daughter) 16 Se	eahase Dr	ive Rehobet	h, Dela	ware 1997	1
	20a. Method of Disposition		20b. Place of Dispo cemetery, cree	osition (Name of	Date	- 7	. Location - City or	
	1 ₺ Burial 2 □ Cremation		'		1			
	'4 □Donation 5 □Other (S	-	Meadowrid		3-29-2	:004 E1	kridge, M	laryland
	21. Signature of Funeral Service	Licensee	W-	2. Name and Addre itzke Fun	ss of Facility eral Home o	f Caton	eville T	nc
	P.OTUA	men >	16	630 Edmon	eral Home o dson Avenue	Catons	ville, MI	21228
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the deeth. Do not ent	ter the mode of dyin	g, such as cardiac or re	spiratory arrest,		Approximate Interval Between
Н	Immediate Cause (Final	0 -						Onset and Death
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ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	feil.				
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W	resulting in death) Last	Due to (or as	a consequence -):					
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			- Registrar	Cer	tificate of Death	Reg. N	102004	09806
			Decedent's Name (First, Middle, La	st)		2. Date of Death Month	Day Year	3. Time of Death
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	Examin		4a. Fecility Name (If not institution, giv		4b. City, Town, or Location of Death		c. County of Death	10
			3122 Howar	1 Rock Ave	Baltimore		N_{i}	14
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-			Usual Residence of Decedent			01-03	120	14.0
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Maryland	2 should be and Mental is marked c	-	19a Informant's Name/Relationship (g Address (Street and Number or Rura		or Town, State, Zip	Code)
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Baltimore,	00		Burial 2 Cremation 3 C	Memoval from State	natory or other place)	104 N	1 ARU A	~
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			22a Part 1 Enter the disease or com	plications that caused the death. Do not enter	600 WS EVTY 13	Stuge	د سار م	Approximate *
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	ires tha signed d be de	by	Part II. Other significant conditions of	ontributing to death but not resulting in the un	derlying cause given in Part I.		use contribute to the	e cause of death?
p	w requir been si should	ed				1 ☐ Yes	2 ☑No 3 ☐ Proba	bly 4 □Unknown
S	N G S	Completed				24a. Was an	24b. Were autop	sy findings available pletion of cause of
Ä	The faw te has b bage 2 st	E				autopsy performed?	death?	
<u>Ta</u>			25. Was case referred to medical		26. Place of Death	1 Yes 2 A	lo 1 Yes 2	2 NO
Division of Vital Records,	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient	Other	ne 5 Residence	6 COther (Specific)	
o			27. Manner of Death	28a. Date of Injury 28b. Time of	28c. Injury at	28d. Describe how inj		
o	ding Ph th. After thi funeral	흥	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Work? M 1 ☐ Yes 2 ☐ No			
<u> S</u>	Attanding r death. sctor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not b	286. Place of injury - At nome, farm, stre	et, factory, office	28f. Location (Street a	and Number or Rural	Route Number.
Ö	after Dire	Certification:	4 Homicide	building, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, Sta	te)	
	spita ours narel filled		29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death	occurred at the time, date and place a	and due to the cause/	e) and manner as sta	ted
	Hos 24 h Fur stely	Medical	(Check only 2 Medical Exar	niner: On the basis of examination and/or inv	estigation, in my opinion, death occurre	ed at the time, date ar	nd place, and due to t	the cause(s)
	To the Hospital or Attand within 24 hours after death To the Funarel Director: completely filled in by the	Me	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month, D	ay, Year)
	P ≥ ⊢ ŏ		I lahar 21	16	115450		29/04	
	7	1	OO Namadanda da da da da da da da da da da da da d				-1101,	
			101	completed cause of death (Item 23a) (Type, F		C 1	DIT I	nD 2120
	Sta		Mchamed Al 31. Date filed (Month, Day, Year)	32. Registrar's Signature	10 D. Green	10 9	Dalla,	MAN STAN
		(-	MAR 3 0 2004	J. Hogistian S digitalian	- m			

			1 - For Amend Item 23a, F		,G829,(03/30/0	tilicate of	Death			1004	09807	
Ī	Physici /Medic		Decedent's Name (First, Middle, Late Kevin Cadalso	Santotome					2. Date of I Month March	Day	Year 2004	3. Time of Death	
1	Examir		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of [unty of Death	1.55 a	
			Laurel Regional H				Laurel			Pr	ince Ge	3. Time of Death 1:53 a th George's thplace (State or Foreign ry Land 10d. Inside City Limits 1 Yes 2 No Nountry? Prican Indian, e, etc. Asian Industry d 2 Dr Code) 0 7 0 7 Town, State ry Land d 20 7 0 7 Approximate Interval Between Onset and Death Very Day Year the cause of death? phably 4 Unknown completion of cause of 2 X No stated. to the cause(s)	
	Funeral Director			ex 7. Age	7	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours		Birth Day, Year) , 1997	9. Birthr Coul Mary	place (State or Foreign http) Land	
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation				1	10d. Inside City Limits	
	e Mar	Director	MD Prince G	eorge's	Lau	rel						1 ☐ Yes 2 ☐ No	
	iih th or 28	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Cour	ntry?	
	s 23e	rai	7812 Aylesford La				2070		·	U.S.A			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "netural", or Itams 23a or 28a-f show any injury or other traumatic event, I'm Medical Ezamener must be notified at once.	by Funerai	11. Marital Status 1 → Never Married 2 → Married 3 → Widowed 4 → Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		H	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin in, Mexican, P Specify:	? (Specify Yes or I Puerto Rican, etc.)		Black, White,	etc.	
50	72 ho netur	eted	15. Decedent's Ec	lucation de completed)		16a. Deced	ent's Usual Occup	ation	workina	16b. Kind	of Business/Inc	dustry	
121	within ane. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		kind of work done of DO NOT use retired isabled	0	working.	1	1.7.		
<u>d</u> 2	filed Hygid other	a	17. Father's Name (First, Middle, Last)			u	Isableu	18. Mother's	Name (First, Midd		sabled		
lan	Aental Aental rked o	To B	Recto Santotome						a Cadals		,		
lan	2 should and Men is marke aumetic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street a	and Number o	r Rural Route Num	ber, City or To	wn, State, Zip	Code)	
	and sealth m 27		Nenita Santotome	/ mother					Laurel,	Maryla	nd 20	707	
ŏ	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐		1		sition (Name of atory or other plac		Date	20c. Locati	on - City or To	wn, State	
Baltimore,	it. Pa intmer intent njuny		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		St.	_	s Cemeter		27/2004		1, Mar	yland	
Ba	permit. Departn Importe any inju		1625km		/ M00	//0	313 Talbo	ott Ave		cel, Ma	ryland	20707	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused to one cause on each line	the death.	Do not ente	r the mode of dying	g, such as car	diac or respiratory	arrest,		Interval Between	
	Physician /Medical		disease or condition Cardiopulmonary Arrest										
В	Examiner		ſ	Due to (or as a Cerebra									
to		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a		•							
	ificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Entir Ur Janyling. Cause (Disease or injury that initiated events.	C.									
Ö,	e exe		resulting in death) Last	Due to (or as a	consequer	nce of):							
68760,	cate b	edical		d									
Box		by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at ti	Fetal de	ath 3 🗆	Ectopic pregnancy Other (specify)				Date of delive Month	,	
P. O.	by the	hys	9 Unknown	9□ Unknown									
Records, F	The law requires that the death certate has been signed by the attendingage 2 should be detached for use	ed by P	Part II. Other significant conditions of Gerebral Palsey	entributing to death but	not resultin	ng in the un	derlying cause give	n in Part I.					
ecc	has be	Completed							24a. Wa:		b. Were autop	sy findings available	
		Co							perf	ormed?	death?		
Vita	ysician: The second control of	Be	25. Was case referred to medical examiner?	Hospital:			Out		Death (Check only	one)			
	Phys r this sral dii	5	1 Yes 2XXNo	1 ☐ Inpatient		Outpatient		4 LI NUISIN	g Home 5 Res)	
0	nding P Ith. :: After I e funera	ation	1XXvatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Injury Work M 1 □ Y	? es 2⊟No	200. Describe	now injury occ	urred		
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely lilled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injun building, etc.	y - At home (Specify)	, farm, stree	et, factory, office		28f. Location City or To	Street and Nu wn, State)	mber or Rural	Route Number,	
	To the Hospital or A within 24 hours after To the Funeral Direction place of the Funeral Direction of the Funeral Directi	Medical (29a. Certifier (Check only one) 2 Certifying Phy 2 Medical Exam	sician: To the best of iner: On the basis of e and manner state		dge, death and/or inve	occurred at the time estigation, in my op	e, date and pla inion, death o	ace, and due to the ccurred at the time	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)	
	To the To the goomp	Me	29b. Signature and title of certifier	01			29c. License	number		29d. Date sig	ned (Month, D	Day, Year)	
/	1		100	ll 1	w	0	06	790	8	3/	22/3	04	
((10)		30. Name and address of person who c	ompleted cause of dea	ith (Item 23		rint) Disen k	3	Varre	e m	0 20	207	
ï	Stat Registra		31. Date filed (Month, Day, Year) MAR 3 0 2004	32. Registrar	's Signature		5 9		<u> </u>				

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State AMEND ITEM #18&19a PER INF G829 3/30/Oberdificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Charles Michael Smith March 28, 2004 0130 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner I 695 @ Exit 16 Woodlawn Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month, Day, Years J 27, 1980 9. Birthplace (State or Foreign Country) California 7. Age (In yrs. last birthday) **Funeral** 1∏M 2□F 608-03-8892 23 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 HNo Md. Baltimore Pikesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 Marshall Ave. 21208 U.S.A. or Itema 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 A No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Restaurant 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Charles Robert Shinn Pamila Sue Smith PAMELA 1964 (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamila Sue Smith - Mother 512 Marshall Ave., Pikesville, Md. 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Department of H Important: If its any injury or of once. 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State *4 □ Donation 5 □ Other (Specify) Metro Crematory April 1, 2004 Baltimore, Md. permit. 21. Signature Furnil Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and ned for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) ian/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Physic 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 99 1 Yes 2 No 3 Probably 4 Unknown Be Completed been 24b. Were aulopsy findings available prior to completion of cause of death?

17 Yes 2 □ No has page 2 autopsy performed certificate Yes 2 No 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) At Scene Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After Injury 1 Datural 5 Pending 3 28 04 unkun Driver of putu involved in collision am 1 ☐ Yes 2 No death. 2 Accident investigation within 24 hours after death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At hon building, etc. (Specify) At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide I695 street Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and man er as stated. Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and male as satisfied.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certile 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. March 28, 2004 who completed cause of death (Item 23a) (Type Print) Penn Street, Baltimore, Maryland 21201

State Registrar 30. Name and address of person

JACK 31. Date filed (Month, Day, Year)

W.

MAR 3 0 2004

DHMH 17 Rev 1/2001

ORIGINAL

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32. Registrar's Signature

		Í	1 - For State (of Maryland / Do	epartment of F Certificate of i	lealth and Me <i>Death</i>	ntal Hygier		09809		
	Physici		Decedent's Name (First, Middle, Last)	1177		2	Date of Death Month	10d. Inside City Limits 1 Yes 2 No Citizen of What Country? USA 14. Race - American Indian, Bleck, White, etc. Specify: White D. Kind of Business/Industry Domestic Iden Sumame) Iffy or Town, State, Zip Code) MD 21043 C. Location - City or Town, State By kesville, MD EL (Box 195) -795-1400			
	/Medic Examin		4a. Fecility Name (If not institution, give street and not bowers) County Com	ımber)		r Location of Death	4				
	Funeral Director		5. Social Security Number 220−22−4239 6. Sex 1	7. Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Yea Jan 20,	9. Birthp 1915	lace (State or Foreign		
	aryland show)r	Usual Residence of Decedent 10a. State 10b. County MD Howard	10c. City, Town	or Location Ott City			11	37		
	with the M 3a or 28e-f	i Director	10e. Street and Number 3630 Rusty Rim		10f. Zip Code	1043	10g. (itry?		
936	be filed within 72 hours after death with the Maryland that Hygiene. od other than "natural", or flams 23a or 28e-f show event, the Mudical Examitrer must be mulified at	by Funeral	11. Marital Status 12. Was De Armed F	No No	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (Specit an, Mexican, Puerto Ric Specity:	y Yes or No- can, etc.)	Bleck, White,	etc.		
Maryland 21215-0036	within 72 hor iene. r than "natura the Mudical E	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	(1-4or 5+)	Decedent's Usual Occup Give kind of work done of life. DO NOT use retired Homemaker	during most of working	16b.		·		
land 2	should be filed nd Mental Hygi marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) Berryman Gollida	7		18. Mother's Name (I	First, Middle, Maide Estep	en Sumame)			
	alth a		19a. Informant's Name/Relationship (Type, Print) Mrs. Deborah Longo (Daug		Mailing Address (Street a 30 Rusty Ri	im Ellicott	City, M		Code)		
Baltimore,	Pages 1 ard ment of Healent: If Item ury or other		20a. Method of Disposition 1 ▼Bunal 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	cemetery	Disposition (Name of , crematory or other place). .ew Mem. Par	ck 3/31/0	, =				
Balt	permit. Page Department of Importent: If any injury or		21. Signature of Funeral Service Licensee	+	Sykesvill	<u>le, MD 2178</u>	<u> 34 (410)-</u>	L (Box 195 795-1400			
	Physician /Medical		23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) 23a. Part1. Enter the disease, or complications that shock or heart failure. List only one cause on the complex of the comple	each line.		grin.	espiratory arrest,		Interval Between Onset and Death		
8760,	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	r as a consequence of	uTI						
.O. Box 687	death certifi e attending i d for use as	Physician/Medic	in the past 12 months?	utcome of pregnancy birth 2 Fetal death mant at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	1		23d. Date of delive Month	ory Day Year		
Ω_	es be	þ	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cause giv	latron.	23e. Did tobacco	o use contribute to th 2 PNo 3 □ Prob	ne cause of death? ably 4 □Unknown		
Vital Records,	(0 -	Completed					24a. Was an autopsy performed?	prior to con death?	psy findings available inpletion of cause of		
Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	A 45500	Oth	26. Place of Death (
Division of		-	27. Manner of Death 28a. Date	/	me of 28c. injur		d. Describe how in	6 ☐Other (Specify jury occurred	7		
Divisi	spitel or Attending Fours after death, eral Director: After filled in by the funering.	Certification:	3 Suicide 6 Could not be 28e. Place	e of Injury - At home, farr ding, etc. (Specify)	m, street, factory, office	28	f. Location (Street: City or Town, Sta	and Number or Rura ate)	l Route Number,		
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai C	29a. Certifier (Check only one) 1	ne best of my knowledge, basis of examination and nner stated.	death occurred at the tin for investigation, in my o	me, date and place, and pinion, death occurred	d due to the cause at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)		
	To ti To ti comp	W	29b. Signature and title of artifier	M.D.	29c. Licens			Date signed (Month, $13/28/200$	Day, Year)		
	N		30. Name and address of person who completed car VIC MADRID, 2070	SAMUET M	ype, Print) ORSE DR.	Columbia	7, mp 2	1046			
	Sta Regist		31. Date filed (Month, Day, Year) 32.	Registrar' Signature	de la company de		-				

	-	For State Registrar	State of M	laryland .	•	artmen <i>rtificat</i>			and M		Reg. No.	200	14	098	811
Physicia	ın	1. Decedent's Name (First, Middle, Las							Nr	2. Date of Domestin Month arch	eath 26	ý	864	3. Time o 8:43	of Death
/Medica Examine	al -	John Hill Sha 4a. Facility Name (If not institution, give Fairhaven Retire	street and number,)		4b. City, Syke		Location o			4c.	County of oward		0.43	
Funeral Director		5. Social Security Number 6. Security Number 225-05-5348		ge (In yrs. last 82	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 11/25/	irth ay, Year) 1921	9	Birthpl Count VA	lace (State try)	or Forei
Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Howard		10c. City. T									10	0d. Inside C	
death with the Maryland rms 23a or 28e-f show rmst be notified at	Funeral Director	10e. Street and Number 7200 3rd.Ave.,Cott	age 157	1 5) 100		10f. Zip 217						zen of Wha	at Coun	try?	
al', or Ite	5	11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Tyes 2 X If Yes, Give Year or Dates:	No		Was Deced f Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:W	White, 6	etc.	
s 1 and 2 should be filed within 72 hc Health and Mental Hygiene. Item 27 is marked other than "natu other treumatic event, the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 1 2			(Give	dent's Usua kind of wo DO NOT us dical	rk done d se retired,	uring mos	t of workir	ng		nd of Busin		lustry	
build be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) Clifford Hill	Shaw	•						(First, Middle Mae S:					
alth and Mental 27 is marked to recumatic even		19a. Informant's Name/Relationship (1 Diane Shaw	ype, Print)		19b. Mailir 7200	3Rd A	(Street a	nd Numbe Cott	age	Route Numb	ber, City o ykesv	r Town, Sta rille,	ate, Zip MD	^{Code)} 2178	4
permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	20b. Plac cem Cres	t Lav	sition (Name matory or o m Mer	n. Ga	ırden	3/29		Mar		svi	11e,	MD
permit Depar Impor any ir		21. Signature of Fymeral Syrvice Jacon	Signature of Fyrneral Survice Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home 736 Edmondson Ave. Baltimore, MD 212 12. Name and Address of Facility Sterling Ashton Schwab Funeral Home 736 Edmondson Ave. Baltimore, MD 212 13. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reagrafatione. List only one cause on each line.										228	nc.	
ysicia	licai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequent consequent s a consequent	ce of):	hea.	,+	fint	ure				į	jeurs	
he death certificate be e. the attending physician shed for use as the buria	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 Fetal de at time of deat	ath 3	Ectopic pr						23d. Date o Month		•	Year
		Part II. Other significant conditions o	ontributing to death	but not resultin	ng in the u	nderlying c	ause give	n in Part I					ite to th	e cause of a	death?]Unkno
The law ate has b page 2 s	Completed									24a. Wa auto peri 1 Yes	opsy ormed?	prio	r to con	osy findings npletion of c	availat cause d
certiti	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpat	ion: 2∏ED	/Outpation	nt 3 🗆 DC	Othe			(Check only		S COthor	(Canaih)		
Jing After fune	\vdash	27. Manner ol Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of In (Month, D		Bb. Time o Injury		8c. Injury Work		2	8d. Describe			<i>Openny</i>	,	
To the Hospitel or Attendi within 24 hours atter death. To the Funeral Director: A completely tilled in by the tr	Certification:	3 Suicide 6 Could not by determined	286. Place of II	njury - At home atc. <i>(Specify)</i>	e, farm, str	eet, factor	y, office		2	81. Location City or To	(Street an own, State		or Ru ra i	l Route Nun	nber,
To the Hospitel or At within 24 hours after or To the Funeral Direct completely tilled in by	edical	29a. Certifier (Check only one) Certifying Ph	ysician: To the bes niner: On the basis and manner s	of examination	idge, deat n and/or in	h occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, a th occurre	nd due to the	cause(s) , date and	and mann place, and	er as sta I due to	ated. the cause(s)
1	Ž	29b. Signature and title of certifier	nD)34	number 849			Mar			0ay, Year) •2004	4
b		30. Name and address of person who	1) 164	5 Libe.	ty	Print) Rd	٤	lders	burs	MD	21	184			
Stat Registra		31. Date filed (Month, Day, Year)		trar's Signatur	4	10: 11									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	004 09811
1. Decedent's Name (First, Middle, Last) 2. Date of Death	3. Time of Death
*Physician Edward Senanayake March 28	2004 2:33 PM
Amedical	unty of Death
ST. AGNES HEALTHCARE BALTIMORE	
Funeral Director 5. Social Security Number 112-50-6026 6. Sex 1 Months Days Hours Min. Feb. 27, 1938	9. Birthplace (State or Foreign Country) Srilanka
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland Baltimore Catonsville	1 ☐ Yes 2X No
Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen	of What Country?
호텔	1
2112 Fernglen Way 2128 U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? Amed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lift Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. If Yes 2 12 No	Race - American Indian,
1 Never Married 2 Married 1 Yes 2 No Specify:	Black, White, etc.
3 Widowed 4 Divorced If Yes, Give 1 Yes 2 No Specify: Speci	Srilankan
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0·12) College (1-4or 5+) Psychiatrist Med	of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+) 5+ Psychiatrist Med	lical Dractice
To a first, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sun	lical Practice
Merina Adin Mendis Senanayake 18. Mother's Name (First, Middle, Maiden Sun 18. Mother's Name (First, Middle, Maiden Sun 18. Mother's Name (First, Middle, Maiden Sun 18. Mother's Name (First, Middle, Maiden Sun	
10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. Street and Number 10f. Zip Code 10g. Citizen 2112 Fernglen Way 21228 U.S.A 2112 Fernglen Way 11. Marital Status 12. Was Decedent Ever in U.S. A med Forces? 1 Yes 2 2 No 1 Yes 2 2 No 1 Yes 2 2 No 1 Yes 2 2 No 1 Yes 2 2 No 1 Yes 2 2 No 1 Yes 2 Xes No Specify: Specify Vision, Mexican, Puerto Rican, etc.) 16b. Kind on 16b	wn, State, Zip Code)
Padmini Senanayake (Wife) 2112 Fernglen Way Catonsville, Mary	land 21228
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location Company or other place)	on - City or Town, State
*4 Donation 5 Other (Specify) Balto./Wash Crematory 4-3-2004 Laurel 22. Name and Address of Facility	, Maryland
20a. Method of Disposition Commetter, crematory or other place	le Inc
1630 Edmondson Ave Catonsville,	-
23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) [Medical Immediate Cause (Final disease or condition resulting in death)	1 Hour
/Medical resulting in death) Due to (or as a consequence of):	
Sequentially list conditions b.	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
Due to (or as a consequence of): The constraint of the constrai	
Cause Disease or injury that initiated events resulting in death) Last Cause Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last Course Disease or injury that initiated events resulting in death) Last	
And the state of t	
1 ive high 2 Fetal death 3 Fectoric pregnancy	Date of delivery
The past 2 months? The past 2 months? 1 Yes 2 No 9 Unknown 9 Unknown	Month Day Year
1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ontribute to the cause of death?
The state of the significant conditions contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use of the significant conditions contributing to death but not resulting in the underlying cause given in Part I.	ontribute to the cause of death? 3 Probably 4 Onknown
1 Yes 2 No	
The law of the law of	b. Were autopsy findings available prior to completion of cause of death?
The state of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other	1 ☐ Yes 2 ☐ No
The state of the s	211 (2)
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occ (Month, Day Year)	Other (Specify)
Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation investigation Month, Day Year) Injury Work?	
27. Manner of Death Same of	mber or Rural Route Number,
4 Homicide determined building, etc. (Specify) 4 Homicide determined building, etc. (Specify) 4 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause (a) and	
Natural 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 5 Pending investigation 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Nucleipolic Place) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Nucleipolic Place) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Nucleipolic Place) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Nucleipolic Place) 28f. Location (Street and	manner as stated. ce, and due to the cause(s)
The state of the s	ned (Month, Day, Year)
rsto la la la la la la la la la la la la la	
1 1/1/2 MAD DO051865 MAD	2CH 28, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ICH 28, 2004
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1132125 CATTS STAGNES MUSPITTE GATT) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	more 120)

			For State Registrar	State of N	Maryland	d / Depa		t of H	ealth a		lental Hyg	0.0	n L	00010
			Negistrar Name (First, Middle,	Last)			imoun	0 0, 2			2. Date of Deat		UH	3. Time of Death
	Physici	an									Month	Day	Yeer	
	/Medi		Hoke L. Sm 4a. Fecility Name (If not institution,		ar)		4b City	Town or	Location o	of Death	March 2	4c. County		11:40 A M
	Examir	ıer											OI DOG!!!	
			4000 N. Charl 5. Social Security Number		I ⊃ I ∠ Age (In yrs. Ia	ast hirthday)	If Under	TIMC 1 Year	ore Ci		8. Date of Birth	n/a	9 Rinh	plece (State or Foreign
	Funeral Director		356-24-5626	1⊠M 2□F	72	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 7.	^{Year)} 1931	Coui	linois
			Usuel Residence of Decedent		12		1				nay /,	1231		TTHUTS
	ehow		10a. State 10b. County		10c. City	, Town or Lo	cation						1	10d. Inside City Limits
	Many Feb	tor	MD n/a		1	Baltin	ore							1 X Yes 2 ☐ No
	r 28a	rec	10e. Street and Number				10f. Zip	Code			1	0g. Citizen of V	Vhat Cou	ntry?
	3a o	Funeral Director	4000 N Charles	Street 15	12			2121	8			Unite	d St	ates
	deatl	Jer	11. Marital Status	12. Was Decede	nt Ever in U.S	S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,
G	or Ite		1 Never Married 2 Marrie			ם כו				, Puerto	Hican, etc.)		k, White,	
9	Per', C	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s: 195	58	1 ☐ Yes	NO LO	Specify:			Specify	: W	hite
20	72 hours after death with the Maryland naturel', or Items 23s or 28s-f ehow disal Examiner; out be notified at	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usua kind of wor	d Occupa	ation	of worki	00	16b. Kind of Bu	siness/In	dustry
21	within ene. than	aldr.	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT us	e retired)	o works	···g	Tows	on	
21	filed withi Hygiene. other than	50		5		Pr	eside	nt				Univ	ersi	ty
pu	be filed within 72 hours after death with the Maryla nal Hyglene. of other than "naturel", or Items 23a or 28a-f ehov event, the Madical Examiner pout be notified at	Be (17. Father's Name (First, Middle, L								(First, Middle, M		e)	
/la	should be nd Mental marked o	2	Claude Hoke Sn	nith					Ber	nice	LaFoli	lette		
Maryland 21215-0036	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Number	City or Town,	State, Zip	Code)
	1 and 2 Health tem 27		Glen Smith/son			7475	01d l	Main	e Tra	il,	Atlanta	, GA	303	28
Sre	of Healt of Healt fitem 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Domewal from Sta	CE	ace of Dispo	natory or of	ther place	9)	03/3	ate 1 / Ω	20c. Location -		
E			'4 □Donation 5 □ Other (Sp		" Dul	aney I	/alley	y Mer	n. Gr	ans.	1704	Timoni	⊥m, N	MD.
Baltimore,	artn orts inju		21. Signature of Fuperal Service L	icensee		22	2. Name and	d Addres	s of Facility	y Ruc	k Towsor	Funer	al Ho	ome, Inc.
m	Den Person) Lt	7			1050 \			To	wson, Ma	rvland	212	74
	76		23a. Part 1. Enter the disease, or o	complications that gaus	ed the death									Approximate Interval Between
	Pnysician		shock, or heart failure. List of Immediate Cause (Final			ana.	.10	0	-11.	. ,	40-11		1 1	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or	Carcin	loma	Of The	< (n	157210	wi	in small	CLEXCGI	IGNT	
	Examiner			200 10 (0)	25 & CO:136Q6	onoa ory.	12	1:0	11	- fa	the small			From
de	23	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	V.	as a consequ		, ,			C / 30	7/43/3		_	
	ned in sit	Exan iner	cause. Enter Underlying Cause (Disease or injury	1										
	al-tra	ха	resulting in death) Last	C. Due to (or	as a consequ	ence of):								
760,	ate be execuie ysician and he burial-tran	call												
89	ficate phy.	_	0.52% PSW NO. 12 134 - 124	g.	T	W.								
×	The law requires that the death certificat tite has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcor	ne of pregnar	ncy						23d Dat	e of delive	anv
Вох	atter for L	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal		Ectopic pro Other (spe					Moi		Day Year
0	by the datached	ysl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknowr			2 00.07 (00.	,						
<u>a</u>	that ed by deta		Part II. Other significant condition	s contributing to death	but not resu	Iting in the u	nderlying ca	ause give	n in Part I.		23e. Did tob	acco use conti	bute to t	he cause of death?
ds	sign d be	d by									1 ☐ Ye	s 2 2 No	3 Prot	ably 4 Unknown
Ö	w requir been si should	ete									24. 116	1		
Vital Records,	has has ge 2 s	Completed									24a. Was ar	y r	Vere auto prior to co leath?	psy findings available mpletion of cause of
F		Ö									perform 1 ☐ Yes 2		Yes	2 No
Zita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				011-		of Death	(Check only one	9)		
of	Physical this call direct	မ	1 ☐ Yes 2 XNo	1 Linpa		ER/Outpatier		_	_ 4 🗆 Nul	-	ne 5 X eside			y)
	ding F	Certification	27. Manner of Death 1 Natural 5 Pending	28a. Date of It (Month, I	Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe ho	w injury occurr	be	
Division	att Sr.:	cat	2 Accident investigation 3 Suicide 6 Could no	at he			М	-	/es 2 □ N					
\leq	or Attendated after death	Ę	4 Homicide determine	and Zoe. Place of	Injury - At hor etc. <i>(Specify</i> ,	me, farm, str)	eet, factory	, office		2	28f. Location (Sti City or Town	eet and Numb , State)	or Rura	al Route Number,
	To the Hospitel or Atti within 24 hours after de To the Funerat Direct completely filled in by the													
	To the Hospitel within 24 hours a To the Funerat I completely filled	edical	(Check only 2 Medical E	Physicien: To the be xaminer: On the basis	st of my knov of examinati	vledge, death ion and/or in	occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ca	use(s) and ma	nner as si	tated. the cause(s)
	the the the the the the the the the the	led	one)	and manner	stated.									
	To To	Σ	29b. Signature and title of certifier	0/2/		-	29c	. License	number	ا وسے دسم		d. Date signed		*
			1 2/6	6		-		0	429	7+	7	March	730	2004
	OLI		30. Name and address of person w		f death (Item	23а) (Туре,	Print)		_	/				
l	UTI		Michael A.Car	ducci M. T	0. 40	1 No.	Brog	dwa	Y, B	alti	more M.) 212	3 /	
	Sta	-	31. Date file of Agrical Agriculture (1997)	32. Regi	strar's Signat	ure	· p		, ,					
igg	Regist	rar	77# 51 G O 2.00	Jan Balling Const	J.S.	A THE STATE OF THE								

				#10c Per in	aryland formar	it Gepa Cer	otment of tificate of	Health a Death	and Mental F	Hygiene 2	004	09813
	Physic	ian	1. Decedent's Name (First, Middl						2. Date of Month	Day	Year	3. Time of Death
	/Medi		Lloyd Alonza	- · ·			-		March	1 26, 2	2004	3:30 A.M.
1	Exami	ner	4a. Facility Name (If not institution)			•	wn, or Location of D		ty of Death	
	Funeral Director	Γ	Oak Crest Vi1 5. Social Security Number 214-18-0180	6. Sex 7. Ag	ge (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under	kville 24 Hrs. 8. Date of Min. (Month, Sept		9. Birthpl Count Vir	e lace (State or Foreign try) ginia
	ס		Usual Residence of Decedent						T-F-		V	SIMIA
	arylar show	_	10a. State 10b. County			Town or Loc	-				10	0d. Inside City Limits
	he M	Directo	Maryland Balti	nore	Par	lville	-	kvi11	e			1 ☐ Yes 2 ☐ No
	with with		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	iry?
	ns 2	Funerai	8810 Walther B	LVd . 12. Was Decedent	Ever in U.S.	13. W	2123	4 Hispanic Ori	nin? (Specify Yes or	United	State	es an Indian
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show appringury or other treumatic event, I'm Medical Evantmer must be indiffed at once.	\$	1 Never Married 2 Marr	Armed Forces?		4	Yes, specify Cub ☐ Yes 2 No		gin? (Specify Yes or , Puerto Rican, etc.)		ack, White, e	etc.
Maryland 21215-0020	hin 72 ho 9. an "netur Medical	Completed	15. Deceden (Specify only highes Elementary/Secondary (0-12)	's Education it grade completed) College (1-4or t		(Give k	ent's Usual Occu ind of work done O NOT use retire	durina most	t of working	16b. Kind of I	Business/Ind	ustry
7	er the	Con	12th		", C	ontrac	tor Eng	ineer	Manager	Martin	Marie	tta
and T	be filk d oth even	æ	17. Father's Name (First, Middle, Lloyd Alonza Sp.						r's Name (First, Mide		me)	
<u> </u>	should be and Mental I a marked of umatic eve	မ							e Isabell			
Σ	d 2 sl th and 7 is r treur		Mrs. Hazel B. St						r or Rural Route Nur			
ē,	s 1 and 2 f Health tem 27 i		20a. Method of Disposition		20b. Plac	ce of Disposi	tion (Name of		Apt.1308	, Parkvi 20c. Location	11e, N	1d. 21234 vn. State
Ê	Pages nent of I nt: If ite iry or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)	3 □Removal from State			atory or other pla Park Cei		03/29/0	4 Woodla		
Baltimore,	permit. F Departmo Importan any injur		21. Signature of Funeral Service			22.	Name and Addre	ess of Facility				iryrand
			23a. Pard. Enter the disease of shock, or hear vailure. But to	+ Kellker	-MOOJ	W 87	28 Liber	rty Ro	ad, Randa	llstown,	mo. 21	133-4784
	Physician		slock, or heart allure. Diet	only one cause on each li	ne.	DO HOT WHEE	the mode of dyl	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Finat disease or condition	Att	eros	clero	xic (and-	waja	0. N:	SCILA	
	Examiner		resulting in deeth)			s a conseque			حارب المحارب	- 12	34.24	<u> </u>
	ed sit	ine		- b. 147 F	or ten	سي ر ج						
	xecut al-tran	Examiner	Sequentially list conditions, if any, leading to immediate		Due to (or as	s e conseque		115	1			to de de de la constante de la
68/6U,	ifficate be executed g physician and as the burial-transit	edicai E	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events	cM'i	16		ne tes	melli	נער		İ	
8	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit		resulting in death) Lest		Due to (or as	a conseque	ence on:					
ŏ g	th cer tendir or use	Physician/M		■ d								-
	the at	ysic	Pert II. Other significent condition						23b. Di	d tobecco use co	ntribute to t	the cause of deeth?
7	that the ed by detac	Ę	Byork Sh	iley Apr	tic v	idve	Pros	Their	10	Yes 2. No	3 Proba	ably 4 🗆 Unknown
necords,	uires sign	d by					n-1		24a We	es an autopsy	24h Were	e autopsy findings
ទ្ច	w req	Completed							per	formed?	com	able prior to pletion of cause
	The law ate has b	E							10	Yes 221No		eath?
ָ פּ	en: 7 rtifical stor, p	Be	25. Was case referred to medical					26. Place	of Death (Check only			Yes 2□ No
5	nysici lis ce I direc	2	examiner? 1 ☐ Yes 2万1 No	Hospital: 1 ☐ Inpatie	nt 2□ER	/Outpatient	3□ DOA Oth		sing Home 5 ∰Re		er (Specify)	
	nding Pt ath. rr: After th	ation:	27. Manner of Death 1 ♣ Natural 5 Pending 2 Accident investigation	ation	y Year) 28	b. Time of Injury	28c. Injur Work M 1		28d. Describe	how injury occur		
	tal or After safter de el Directe led in by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ıry - At home . <i>(Specify)</i>	, farm, stree	t, factory, office		28f. Location City or T	(Street and Numb own, State)	er or Rural F	Route Number,
	n 24 hou n 24 hou ne Funer pletely fil	edical	29a. Certifier 1 ☐ CertifyIng (Check only one) 1 ☐ CertifyIng	Physiclen: To the best o kaminer: On the basis of and manner sta	examination	dge, death of end/or inves	ccurred at the tin stigetion, in my o	ne, date and pinion, death	place, end due to the occurred at the time	e cause(s) and ma e, date and place,	inner as state and due to th	ed. ne cause(s)
ļ	To the Com	Σ	29b. Signature and title of certifier	0	1 .		29c. License	e number		29d. Date signe		
	0.		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 lune	CP			3019	5 5	march	21,	2004
	1		30. Name and address of person w		ath (Item 23	a) (Type, Pri		10	2 (23	4		·
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Spo	uls	4				·

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. William G. Schreieck, Jr. Script Leck, Jr. State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 1 - State of Maryland, Department of Health and Mental Hygiene 2 - State of Maryland, Department of Health Andrew 2 - State of Maryland, Department of Health Andrew 2 - State of Maryland, Department of Heal 09814 04 - 17591. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Vaar William G. Schreieck, Jr March 10, 2004 9:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 3 Valley Arbor Court Essex Baltimore County F Apt If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth
(Month, Dey, Year)
July 14, 1966 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 5. Social Security Number **Funeral** 1**⊠**M 2□F 37 Director 219-98-5511 Usual Residence of Decedent Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Item 27 is marked other than "natural", or items 23s or 28a-f abov other traumatic event, the Medical Exantian must be multiplied at 1 ☐ Yes 2X No MD Baltimore Essex Direct the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 3 Valley Arbor Court #F 21221 IISA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: δ Specify: white 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William G.Schreieck, Sr Jean Gauither 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Riverthorn Road Baltimore, MD 21220 Michelle Hodges/sister 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State `4 □Donation 5 🖔 Other (Specify) in state 21. Signature of Euneral Service Licensee Ronal Id S. Wade State and Address of Faculty and 655 W. Baltimore Street pector vini Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrhythmia /Medical Due to (or as a consequence of) Examiner Myocardial Fibrosis Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 the attending physicien thed for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 90 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 has certificate 2 🗆 No 2 No Yes Yes or Attending Physician: ector, 25. Was case referred to medical examiner? Be 26. Place of Death (C) Other $_4 \square$ Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) At SCENE Hospital: 12⊠Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 ANatural 5 Pending investigation within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XMedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical QRe) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 11, 2004 30. use of death (Item 23a) (Type, Print) 32. Registrar's Signature 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) State Registrar 2004

DHMH 17 Rev 1/2001

ORIGINAL

Physici	an	1- For Amend Items 9,11,12,15,a,b,19a,b,201,b,c,21,22 per Ff Registrar 1. Decedent's Name (First, Middle, Last) MAY BOLOGE Spivat	2.	Date of Death	10. 2004 Year	0 9 8 1 5 3. Time of Death
/Medic Examin	cal	4a. Facility Name (If not institution, give street and number) 2445 Ly 110 mg V 1/2 R 89 5, 1 ver	ocation of Death	1ar 18		
Funeral Director		5. Social Security Number 098-05-5797 Usual Residence of Decedent	Hours Min.	Date of Birth (Month, Day, Yea V 1, 19]	ri Cou	place (State or Foreign ntry) YOCK
72 hours atter death with the Maryland natural", or Items 23e or 28e-f ehow item Examiner mant be notified at	Director	10a. State MD 10b. County 10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 ☐ Yes 2 X No
ath with t	rai Dir	10e. Street and Number 2445 Lyttonsville Road #801 2091			itizen of What Cou	
172 hours after death with the Marylar "natural", or Items 23e or 28a-f show calcal Estantion mant be notified at	by Funerai	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Never Married 4 Divorced 12. Was Decedent Ever in U.S. Armed Forcas? 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Neve	panic Origin? (Specify , Mexican, Puerto Rica Specify:	Yes or No- in, etc.)	14. Race - Ameri Black, White, Specify: Wh	
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permil. Pages Department of I Importent: If its any injury or o		1 □ Burial 2 X Cremation 3 □ Removal from State 1 □ Donation 5 X Other (Specify) in state 1 □ Chesapeake Crematory	3/26/2004 of Facility Rapp ₆ I	Belta Ameral & C		
Physician and // / / / / / / / / / / / / / / / / /	licai Examiner	23a. Parkt. Enter the disease or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	such as cardiac or res	spiratory arrest,	· b,	Approximate Interval Between Onset and Death
death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown			23d. Date of delive	ory Day Year
luires that the d	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
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To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, check only and manner stated. 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, check only and manner stated.	ion, death occurred at	the time, date an	d place, and due to	the cause(s)
vill Con	Σ	29b. Signature and title of certifier 29c. License in 2			ite signed (Month, I	
7 7		20 Name and address of passes who completed across of death (law 20-) (T O-1)	1	I do wife		

			1 - For State Registrar	State of Maryland /	Departr Certif	ment of H icate of I	lealth and M Death	ental Hyg	iene 2004	09816
	Physici		1. Decedent's Name (First, Middle, Last) Kenneth	Stumptner				2. Date of Death Month	Day Year	3. Time of Death
) 	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give s Mujersity of Marylo 5. Social Security Number 212-20-6456	ind Medical Sy	birthday) If		Location of Death MOVC If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 2	4c. County of Death n/a 9. Birthp Cour	place (State or Foreign
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Md. Balti		own or Location	on				0d. Inside City Limits 1 ☐ Yes 2 ※ No
	3a or 28a-	i Director	10e. Street and Number 1710 Brookview	Rd.	1	Of. Zip Code	1222	10	og. Citizen of What Cour	itry?
920	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other then "natural" or itema 23e or 28e-f show marked other then "natural" or itema 25e or 28e-f show mails event, it a Medical Exertina mail be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	II Ye	Decedent of His, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerlo I Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
21215-0036	within 72 houene. then "nature he Medical E	Completed	15. Decedent's Edur (Specify only highest grade Elementary/Secondary (0-12) 10 yrs.		(Give kınd life. DO f	s Usual Occupa I of work done o NOT use retired ntenan	during most of workii)	ng	Armco ste	
Maryland 2	be filed Ital Hygi od other	To Be Co	17. Father's Name (First, Middle, Last) LeRoy Stumpt	ner	nar		18. Mother's Name Ruth	(First, Middle, N	faiden Sumame)	<u>CT</u>
	od 2 ulth a 27 ls	0 9	19a. Informant's Name/Relationship (Type Robert A. Stump	son			and Number or Rura Dr. Bell		City or Town, State, Zip	Code)
altimore,	permit. Pages 1 ar Department of Hea Importants if itam eny injury or othe once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ R 14 □ Donation 5 □ Other (Specify)	emoval from State 20b. Place ceme Meac	of Disposition of the o	n (Name of ry or other place dge Ce	e) March	ate 29	20c. Location - City or To Elkridge	wn, State
Ball	Depart Depart Import eny in		21. Signature of Fun, ral Service License	291	Coi	me and Addres nnelly 10 Sol		Home	Of Dundal 21222	k
	Physician /Medical Examiner		23a. Paryf. Ehter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	ce of):			r respiratory arre	st,	Approximate Interval Between Onset and Death
58760,	physician and prise the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):	Diso	rder			
P.O. Box 68	death certif e attending ed for use as	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		opic pregnancy ner (specify)			23d. Date ol delive Month	ry Day Year
	The law requires that the to be a signed by the base been signed by the bage 2 should be detache	ed by Ph	Part II. Other significant conditions con Acute Renal	tributing to death but not resulting	g in the underl	lying cause give	en in Part I.	23e. Did tob	acco use contribute to th	e cause of death?
al Reco	sician: The law re certificate has be- lirector, page 2 sho	Completed				-		24a. Was an autopsy perform	prior to con	osy findings available inpletion of cause of
Division of Vital Records,	ding Phy h. After this funeral d	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation		b. Time of Injury	DOA Other	at 2	ne 5 ☐ Resider	nce 6 □Other (Specify w injury occurred)
DIVISI	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, t	factory, office	2	8l. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	he Hospit n 24 hour na Funera ptetely fille	edical	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowled ter: On the basis of examination and manner stated.	dge, death occ and/or investi	curred at the tim gation, in my op	ne, date and place, a pinion, death occurre	nd due to the can d at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
	withi To t	M	29b. Signature and title of certifier		Lee, My	1	number	29	d. Date signed (Month, 1)	
	Sta	te	30. Name and address of person who co 22 S. Gyecinu 31. Date filed (Month, Day, Year)	32. Registrar's Signature	Balt	more	, MD	2120	/	
	Registr	201	MAR 3 0 2004	penara &	Low	als!				

State of Maryland / Department of Health and Mental Hygiene 2004 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month HENRY SCHMIDT 7:25 AM MAKCH 24,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A BALTIMORE JOHNS HOPKINS BAYWIEW MEDICAL CENTER 8. Date of Birth (Month, Day, Year) Oct.5,1928 Birthplace (State or Foreign Country) **Funeral** 1 AM 2 ☐ F Days Hours 216-24-3887 Director 75 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Directo Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 3827 Lyndale Avenue or Items 23a 21213 U.S.A. Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 A Yes 2 No
If Yes, Give
Year or Dates: 45-55 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced "netural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Printing Company Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be innent of Health and Mental ant: If Item 27 is marked o Henry R. Schmidt Ruth Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Schmidt-wife 3827 Lyndale Avenue Baltimore, Maryland 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Balt./Wash. Crematory 3/27/04 * 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home 21. Signature of Funeral Service Lice 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 10052 6415 Belair Road Baltimore, Maryland 21206 shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** A systole

Due to (or as a consequence of): MINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neumonia 14 Days o the Hospitel or Attending Physicien: The law requires that the death certificate be executed ASFIRATION Division of Vital Records, P.O. Box 68760 physicien PARKINSONS Completed by Physician/Medical DISEASE IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death Day 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HIP FRACTURE, FALL, CORONARY ARTERY DISEASE, 1 ☐ Yes 2 ☐ No 3 Probably HYPERTENSION, SMOKING 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To his After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. SUBJECT fell 1 ☐ Yes 2 No 2 Accident
3 Suicide 10/04 UNKNOWM I Director: investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 2120 Lindale AVE. RAHIM ever, WD 4 Homicide residence within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 MARCH 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER MENCHEL MD 4940 EASTERN AVENUE, BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

MAR 3 0 2004

				rland / Department of Health ar Certificate of Death	nd Mental Hyd	_	09818
	Physic /Med	ical	Decedent's Name (First, Middle, Last) SIDNEY	SAPERSTEIN	2. Date of Dea Month MARCH	26 ^{Day} 2004 ^{Yeer}	3. Time of Death 3:20 P M
	Exami Funeral Director		4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHR 5. Social Security Number 219-18-1283 AM 2□ F 7. Age (In	yrs. last birthday) If Under 1 Year If Under 24	ON		TIMORE place (State or Foreign try) MD
	th the Maryland or 28a-f show	irector	Usual Residence of Decedent	c. City, Town or Location RANDALLSTOWN 10f. Zip Code			0d. Inside City Limits 1 ☐ Yes 2 ☐ No
John	1215-0036 within 72 hours after death with the Maryland ene. than "natural, or items 23a or 28a-f show the Madical Examiner must be notified at	ed by Funeral Director	8902 MEADOW HEIGHTS ROAD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education	If Yes, specify Cuban, Mexican, F. 1 ☐ Yes 2 ☐ No Specify:		Specify:	etc. WHITE
3120	N gō	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) MANAGER 18. Mother's	1	FURNITURE ST	,
7	■ ■ ■ ■ ●	To Be	MAYER 19a. Informant's Name/Relationship (Type, Print)	SAPERSTEIN IDA 19b. Mailing Address (Street and Number of		TER	RLITZKY
120/10	e, lan Heall Heall ther		1 Durial 2 Cremation 3 Removal from State	8902 MEADOW HEIGHT Ob. Place of Disposition (Name of cemetery, crematory or other place)	S ROAD - RA	ANDALLSTOWN, 20c. Location - City or To	MD 21133 wn, State
3	Baltimore permit. Pages 1 a Department of He Important: If item sny injury or oth		* 4 Donation 5 Other (Specify) 21. Signature: 1 Fineral Service Licensee	BETH EL MEMORIAL PARK 3 22. Name and Address of Facility 8900 REISTERST	SOL LEVI	RANDALLSTO NSON & BROS. PIKESVILLE,	, INC.
•	Physician /Medical Examiner	Examiner	23a. Part. Enter the diseadee, or complications that caused the candidate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events	nic Cardinyoyata	rdiac or respiratory arre		Approximate Interval Between Onset and Death
	. Box 68760, death certificate be executed e attending physician and d for use as the burial-transit	Physiclan/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Due to (or as a cond	egnancy Fetal death 3 □Ectopic pregnancy		23d. Date of deliver	ry Day Year
150	S, P.O ss that the gned by th	þ	9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to the	e cause of death?
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3.	on of ding Phys n. After this funeral di	sation: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 27. Manner of Death 1 No Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	2 ER/Outpatient 3 DOA Other: 4 Nursin 28b. Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	Death (Check only one ng Home 5 Resider 28d. Describe how	nce 6 Dother (Specify)	hupier
1	Divisi To the Hospitel or Attention 24 hours after death Within 24 hours after death To the Funerel Director:	Certification:	building, etc. (Sp		City or Town,	,	
	To the Hosp within 24 ho To the Func completely f	Medical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my cone) 13 Certifying Physician: To the best of my cone and manner stated.	knowledge, death occurred at the time, date and p mination and/or investigation, in my opinion, death of 29c. License number	occurred at the time, da	te and place, and due to	the cause(s)
	7		30. Name and address of person who completed cause of death (D 58303	1	d. Date signed (Month, D	2-00 G
	V Sta	ite	Arron Charles MD (6600) 31. Date filed (Month, Day, Year) 32. Registrar's Si	of N. Chartes St To	m hoeld	0 21204	l l
	Regist		MAR 3 0 2004	p spark			

			1 - For Stete Registrar	Sta	te of M	laryland		artment <i>rtificate</i>			nd Me		giene Reg. No	/ 11 11 11	09819
	Physici /Medi		1. Decedent's Name (First, Mic Myrtle	dde, Last) Todd							1	2. Date of De Month March	Day	y Year 2004	3. Time of Death 5:45p M
	Examir		4a. Facility Name (If not institut Fairhaven He)		4b. City, T Sykes			Death			County of Dea	
	Funeral Director		5. Social Security Number 218-09-7111	6. Sex 1 □ M 2 5	¬ -	ge (In yrs. las 95	t birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	3. Date of Birt (Month, Day July 7	h y, <i>Year)</i> 190	Co	hplace (State or Foreign buntry)
	e Maryland te-f show	ctor	Usual Residence of Decedent 10a. State 10b. Cour Md C	arroll		10c. City, 1	Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with th	ral Dire	10e. Street and Number 7200 Third	Avenue				10f. Zip 0					10g. Citi USA	izen of What Co	ountry?
980	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 show dical Examiner must be matified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ M 3 □ Widowed 4 □ Divorc	arried 1 If Ye	Decedent ed Forces Yes 2 es, Give r or Dates:			Vas Decede f Yes, specif		oanic Origi Mexican, Specify:	in? (Speci Puerto Ri	ify Yes or No- can, etc.)	-	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-1 show any injury or other treumatic event, the Modical Examiner must be notified at ange.	Completed	(Specify only high		eted) ege (1-4or		(Give life. L	lent's Usual kind of work DO NOT use	done dui retired)	on ring most	of working			nd of Business	Industry
Maryland 2	uld be filed Aental Hygie rked other tic event, II	To Be Co	12 17. Father's Name (First, Middl George J.						1	8. Mother Anna		First, Middle,	Maiden	Sumame)	
Mary	id 2 shoulth and h		19a. Informant's Name/Relatio											r Town, State, 2	
Baltimore,	Pages 1 an nent of Heal ent: If item ? ury or other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other	n 3 □Removal		20b. Plac	e of Dispo: etery, cren	sition (Name natory or oth Cy Cre	of er place)		Dat	е	20c. Lo	nington cation - City or esville	Town, State
Balt	permit. Departr Importe eny inju		1. Signature of Funeral Service Licensee P.O. Box 195 Syle 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care									ht Fun 11e, M	eral	L Home 8 L784	Chapel
	rnysician /Medical Examiner		23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final disease or condition resulting in death)	st only one cause	Cere	d the death. I	her	nurrh			ardiac or r	espiratory ari	rest,	70	Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1		a consequen									
P.O. Box 68	The law requires that the death certifica ite has been signed by the attending ph bage 2 should be detached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	1 🗆 l	Live birth	of pregnancy 2 Fetal de t time of death	ath 3 🗌	Ectopic preg Other <i>(spec</i>					2	3d. Date of deli Month	very Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant condi	tions contributing	to death b	out not resultin	ng in the un	derlying cau	se given i	in Part I.					the cause of death?
Vital Records,		Completed										24a. Was a autops perform	Sy.	24b. Were aut prior to death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of
of Vit	Physicien: this certifical ral director, p	To Be	25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No	Hospital	1 🗆 Inpatie	ent 2 ER/	/Outpatient	3□ DOA	04			Check only on 5 ☐ Reside		□Other (Spec	ify)
Division o	ling After une	Certification:	Z	tigation	Date of Inju (Month, Da	ry 281 y Year)	b. Time of Injury	28d M	. Injury at Work? 1 ☐ Yes	: s 2 □ No		d. Describe ho	ow injury	occurred	
Divi			4 Homicide deter	mined 289.		ury - At home c. (Specify)						City or Towr	n, State)		ral Route Number,
	the Hospitel hin 24 hours a the Funerel mpletely tilled	Medical	one)		o the best the basis of manner sta	f examination	dge, death and/or inv	occurred at estigation, in	the time, my opini	date and pion, death	place, and occurred	at the time, d	ate and	place, and due	to the cause(s)
	To To	2	29b. Signature and little of certif	n. 1	~				icense ni 2222				9d. Date Nurc	signed (Month	Day, Year)
	V		30 Name and address of perso	n who dompleted	cause of d	NIVA	a) Type, F	Print) Sil	esVI.	lle.	mo	217			,
	Sta Registr		31. Data iled Month, Galy, Yea	4 See	32. Registra	are Signature	المان	,)		1				-	

			1 - For State Registrar	_	epartment of Health and Certificate of Death		ene g. No. 2004	09820
	- :		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio				TOMAS	MARCH	24 2004	16:32 M
	Examir	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of D	eath	4c. County of Death	
			51 - IAGN CS 1105 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	BALTMORE day) If Under 1 Year If Under 241	Hrs. 8. Date of Birth	9. Birthol	lace (State or Foreign
	Funeral Director			M OFFICE		Ain. (Month, Day,	Year) Coun	GINIA
	D.		Usual Residence of Decedent					
	arylar ehow	-	10a. State 10b. County	10c. City, Town	17	0-0	/	0d. Inside City Limits 1 Yes 2 No
	28a-f	Director	10e, Street and Number		10f. Zip Code	RE CIT	g/Citizen of What Coun	trv?
	with with	흐	/	LBOURNE ROA	0.0	/	11.5A	,
	me 2:	Funerai	00.	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, Pi	? (Specify Yes or No-	14. Race - America Black, White,	
9	within 72 hours after deeth with the Maryland ane. then "naturel", or Items 23s or 28s-f show the Madical Exertiner has be motified at	Fui	1 Never Married 2 Married	1 Yes 2 No	1 ☐ Yes 2 ☒ No Specify:	deno nican, etc.)	Specify:	atc.
215-0036	hours urel',	d by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:		1.	6b. Kind of Business/Inc	ACK
15	in 72 in 72	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Decedent's Usual Occupation Give kind of work done during most of life. DO NOT use retired)	working	OD. KING OF BUSINESSAMO	iustry
212	filed with Hygiene. ther ther int, the M	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEMAKEN	2	OWN H	OME
	be filed tat Hygir d other event, II	Be C	17. Father's Name (First, Middle, Last)	^	18. Mother's	Name (First, Middle, M.		/
Maryland	Men Men arke	Tol	FRANK	DYSO	N DOR	OTHY		ERSON
Mar	12 sho h and 7 ts ma trauma		19a. Informant's Name/Relationship (Typ	19b. 1	Mailing Address (Street and Number o	r Rural Røute Number,		
	1 and Health em 27		20a. Method of Disposition	20b. Place of I	Disposition (Name of	Date 2	Oc. Location - City or To	wn, State
nor	Pages nent of int: If it		1/2 Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State Cometery Fowk	crematory or other place)	-31-04 (REW VIA	revolu
Baltimore	글 문문 글 .		21. Signature of Funeral Service License		00.11	BROWN	4 11	L HOME
ä	Depa trnpo any i		Lietuch 1	Milliam	2140 N. FULTO		ALTIHORE, M	0.21217
			23a. Pert1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Do not e cause on each line.	at enter the mode of dying, such as car	diac or respiratory arres	st,	Approximate Interval Between
43	Physician		Immediate Cause (Final disease or condition	METASTATIC	LUNG CANC	ER		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
Dr.	uted d ansit	Examiner	Cause (Disease or injury that initiated events					
o	te be executed ysicien and ne buriat-transit		resulting in death) Last	Due to (or as a consequence of):			
3760,		icai						
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	IF FEMALE:					
Box	attend for us	cian	in the past 12 months?	8c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive - Month	ny Day Year
P.O.	y the	ysic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9□ Unknown	o di ottioi (spoony)			
	s that ned b	y Pi	Part II. Other significant conditions con	tributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to th	e cause of death?
Records,	aquire en sig	ed b				1XYes	s 2 □ No 3 □ Prob	ably 4 Unknown
ဝ၁	law re as bee	piet				24a. Was an autopsy	24b. Were autor	psy findings available inpletion of cause of
<u>m</u>	The ate ha	Com				perform	ed? death?	2 No
Vital	Physicien: this certificated fail director, it	Be	25. Was case referred to medical examiner?	ospital:	Othor	Death (Check only one		
of	Physic this c	To.	1 Yes 2 No 27. Manner of Death	1 x inpatient 2 LEH/Out	Datient 3 DOA 4 NUISII	ng Home 5 Resider 28d. Describe how	nce 6 Other (Specify	9
on	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation		me of ury 28c. Injury at Work? M 1 Yes 2 No		, injury cooding	
Division	Atten r deal sctor	ifica	3 Suicide 6 Could not be	28e. Place of Injury - At home, fare building, etc. (Specify)	n, street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura	l Route Number,
Ö	s afte el Dire	Certification:	4 - Hollicide	building, etc. (Specify)		City of Town,	State)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examin	er: On the basis of examination and	death occurred at the time, date and p for investigation, in my opinion, death of	lace, and due to the car occurred at the time, da	use(s) and manner as st te and place, and due to	ated. the cause(s)
	o the o the o the	Med	one) 29b. Signature and title of certifier	and manner stated.	29c. License number	29	d. Date signed (Month, I	Day, Year)
	F ≯ F ŏ		> othan_	DR.	P1669	3 M	HRCH 24	2004
	'n		30. Name and a dress of person who co	mpleted cause of death (Item 23a) (ype, Print) 401)	(ATON A	VENUE	
	3		DR SARUMI	ST. AGNES	Hospira BAL	TIMORE.	MO 21	229
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	,			
DH	Regist	-0	MAR 3 0 2004	Januar G	P1669 Yye. Print) 400 HOSPITAL BAL			

DHMH 17 Rev 1/2001

THOMAS

DHMH 17 Rev 1/2001

Registrar

MAR 3 0 2004

State of Maryland / Department of Health and Mental Hygiene 2004 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Year **Physician** 7.15 A.A Wible Erelyn 28 2004 march /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Death Examiner Lorien Nursing Center Mt. Airy Carrol1 If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6 Sex **Funeral** Days Hours Months 1 □ M 2 📈 F NJ **Director** death with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examinar must be notified at MD 1 ☐ Yes 2 🕅 No Carrol1 Westminster Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 205 St. Mark Way Apt. 403 21158 USA 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ∑ No
If Yes, Give
Yeer or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours efter 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: 3altimore, Maryland 21215-0020 White Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Victor Chamberlain Hinda Loson 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Mr. Joseph B. Wible (Spouse) c/o: 411 Walnut Drive Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Peges 1 ment of F tant: If It 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation Srv 3/30/04 Sykesville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility.
HAIGHT FUNERAL HOME & CHAPEL (PO Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Parietal intra cramial Hemorrhage

Due to (or as a consequence of):

mal Febrillation Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attending physician enditor use es the bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the s should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed hes 1 ☐ Yes 2 ☐ No TLIYOU ZINO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1. Naturel 5 Pending 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter de To the Funeral Directo completely filled in by the 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide edical 29a Certifier 🔑 🕳 🕶 tifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier March 29 D30641 201 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) RIVER NECK ROAD BARTMORE MINGUAN 201-109 Back Sabapalhi Registrar's Signature State Registrar

Gerrad Webb 04-02056 MAN arrend item#23a,27, PER ME. (831,5/13/0/eg

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AN	For State Registrar	State of Maryland / Dep Ce	artment of Health and M ertificate of Death	fental Hygiene Reg. No.						
Physician	1. Decedent's Name (First, Middle, Last) Gerred Romier	Decedent's Name (First, Middle, Last) 2. Date of Death Month Day								
/Medica Examine	al	treet and number)	4b. City, Town, or Location of Death Randallstown	4c.	1 23, 2004 1820P M 4c. County of Death Baltimore					
Funeral Director	5. Social Security Number 6. Sex		If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)						
anyland •how	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town or I			10d. Inside City Limits 1 ☐ Yes 凝☐ No					
with the M	10e. Street and Number 9065 Meadow Height 11. Marital Status 1 Never Married 2 Married		10f. Zip Code 211.33	10g. Cit USA	10g. Citizen of What Country?					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health and Mental Ptygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-1 ehow eny Injury or other traumatic event, the Medical Exeminer maint be notified at once.	3 ☐ Widowed 4 ☐ Divorced		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black					
Maryland 21215-0036 do 2 should be filed within 72 hours aft th and Mental Hygiene. To te marked other than "natural", or traumatic event, the Medical Exprintmental Control of the Medical Exprintment of the Medical Exprin	15. Decedent's Educity only highest grade (Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+) (Given the completed)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) cr Worked	king	16b. Kind of Business/Industry N/A					
yland Suld be filed Mental Hygerked otheratic event,	UNK.	17. Father's Name (First, Middle, East)								
and 2 sho ealth and m 27 ts m	19a. Informant's Name/Relationship (Ty, Gina Renee Webb/Mo		The state of the s	altimore, M						
Baltimore, sermit. Pages 1 an Depertment of Heal mportant: If Item 2 my Injury or other	20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State Metro Cr	rematory or other place) rematory Inc. 3-28	3-04 Ba	altimore, MD					
Ball permit Deper Impor	Edward A. Green	21. Signature of Funeral Service Licensee 22. Name and Address of Facility MacNabb Funeral Home, P.A. Fdward A. Gregorchik 23. Pert 1. Enter the disease, or amb lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 23a. Pert 1. Enter the disease, or amb lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228								
876(Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	ric Granulomatosis							
P.O. Box 6 that the death certific ed by the attending r detached for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	112 months? 4 Pregnant at time of death 5 Other (specify) Month								
Cords, P.	Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.		d tobacco use contribute to the cause of death? Yes 2♥No 3□Probably 4□Unknown					
Record The law requate has been page 2 should	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1. 22 Yes 2 □ No					
of Vita hysician his certifi	25. Was case referred to medical	Hospital: 1 Inpatient AMER/Outpat 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at Work? M 1 □ Yes 2 □ No	6 Other (Specify) ry occurred						
Division Attention 1.24 hours after death Funeral Director: letely filled in by the		4 Homicide determined 200. Place of injury - A notine, faths, factory, office building, etc. (Specify)								
To the Hos within 24 ho To the Fun completely	29a. Certifier (Check only one) 29b. Signature and title of certifier	ner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	ed at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)						
- Star	Jashez	freely MA ompleted cause of death (Item 23a) (Typ	O.C.M.E.	Má	March 24, 2004					
Stat	Jasha Z Giveent		11 Penn Street, Ba	ltimore, Mar	ryland 21201					

		•	For State Registrar		State of Ma	State of Maryland / Department of Health and Mental H Certificate of Death					łygiene Reg. No. 2004 09824			
	1. Decedent's Name (First, Middle, Last) Physician Alexander								2. Date of Dea Month March					
	/Medic Examin		4. County of Death								rd			
	Funeral Director	5. Social Security Nu	6252	MM 2 F	Months Days Hours Min.			(Month, Day		9. Birthplace (State or Foreign Country) South Carolin				
Maryland 2121	aryland show d at	To Be Completed by Funeral Director	Usual Residence of 10a. State	10b. County		10c. City, T								nside City Limits
	with the Ma a or 28e-f		MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Columbia 10565 Route 108 21044 USA						zen of What Co	ountry?				
	J within 72 hours after death with the Maryland plane. I than "naturel", or Items 23a or 28e-f show It e Marical Examiner must be notified at		11. Marital Status 1 Never Marrie	ed 2 Married	12. Was Decedent Armed Forces? 1 Yes 2 X			Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 No			USA	14. Race - Ame Black, Whit Specify: B1	te, etc.	·
			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				(Give kind of work done during most of working life. DO NOT use retired)					6b. Kind of Business/Industry Y. Transit Auth.		
	d 2 should be filed in and Mental Hygis T Is marked other treumetic event, III		17. Father's Name (_	ne (First, Middle,	Maiden	Sumame)		
	1 and 2 shou Health and M em 27 Is mar ether treumet		19a. Informant's Na Alexand		Туре, Print) hitener/:	son	105	ing Address (Street	and Number or Ru	ıral Route Numbe	r, City o	r Town, State,		(e)
altimore,					Removal from State	20b. Plac cem Colu	mbia	osition (Name of omatory or other place Mem. Pa	rk 3/26		Cla		le,	MD.
Balti	permit. Pages Department of Importent: If it any injury or once.		21. Signature of Fur	ras	1		5.5	2. Name and Addre	Knolls	Rd.Co	Luml			-
Jr.	cate be executed // Medical Examine purial-transit the burial-transit	al Examiner	23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition											
P.O. Box 68760,			shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A cute send failure. List only one cause on each line. Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate. Due to (or as a consequence of): Due to (or as a consequence of):											
			if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
	cate cate	/Medical	IF FEMALE:		d23c. If yes, outcome							23d. Date of de	livery	
	that the death of the by the attended for u	Medical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1							Month Day Year				
	quires that n signed by		Tarring and a significant state of the signifi							pacco use contribute to the cause of death? es 2 □ No 3 □ Probably				
Vital Records,	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as								24a. Was autop perfor 1 🗆 Yes	autopsy performed? performed? death?				
Vita	Physician: Th rthis certificate ral director, pag		25. Was case referred to medical examiner? 1 Yes 2 No											
_	e fe		27. Manner of Death Natural Control Accident	h 5 ☐ Pending investigation	28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury M 1 ☐ Yes 2 ☐ No			28d. Describe h	3d. Describe how injury occurred					
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		3 Suicide 4 Homicide	6 Could not be determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	Son Twit		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suram Abdo 5005 Signal Bell Lane Claribuselle MD 21029								2004			
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bell Lane Clarlesulle MD 21029											
	Sta Regist	ate rar		of filed (Month, Day, Year) MAR 3 0 2004 32. Registrar's Signature										

		1 - For State Registrar		Department of Health and Certificate of Death	Reg. i	2004 0982
Physici /Medio Examir	cal	Decedent's Name (First, Middle, Last Paul Murray War Sacility Name (If not institution, give	burton	4b. City, Town, or Location of Dea	Mar 2	Day Year 12:00 F
Funeral Director		Howard County 6 5. Social Security Number 6. Sec 259-74-9764 Usual Residence of Decedent	General Hospit X Xu 20 F 7. Age (In yrs. last b	al Columbia, inthday) If Under 1 Year If Under 24 Hi Yrs. Months Days Hours Min	S. 8. Date of Birth (Month, Day, Yea	oward 9. Birthplace (State or Ford Country) 1946 Canada
r 28a-f show	Irector	10a. State 10b. County MD Howard 10e. Street and Number	10c. City, Too	wn or Location bia 10f. Zip Code	10g. (10d. Inside City Lir 1 ☐ Yes 2 ☒ Citizen of What Country?
"natural", or items 23s or 28s-f show alical Exercites must be notified at	by Funeral Director	5860 Thunder Hi 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	11 Rd. A 3 12. Was Decedent Ever in U.S. Ammed Forces? 1 A yes 2 D No Viet If Yes, Give Year or Dates: Nam	21 0 4 5 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Râce - American Indian, Black, White, etc. Specify: White
than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	(e completed) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking	Kind of Business/Industry
ntai Hyg ed othe event,	To Be Co	12 17. Father's Name (First, Middle, Last) Thomas Warburto			anic Se ame (First, Middle, Maide on Kingdo	,
Health and tem 27 is m other treum		19a. Informant's Name/Relationship (T) Margaret R. McC 20a. Method of Disposition	arthy/friend !	b. Mailing Address (Street and Number or F 5860 Thunder Hill of Disposition (Name of	Rural Route Number, City Rd/Colum	or Town, State, Zip Code)
Department of importent: if it importent: if it importent: if it imply or concepted.		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Light	Removal from State Balto	D/Wash.Crematory of other place) 22. Name and Address of Facility Wi	5/2004 Lau tzke Fune	rel, MD.
ysician Medical aminer	er	Immediate Cause (Final disease or condition resulting in death)	A A		ac or respiratory arrest,	Approximate Interval Between
ysician and ne burial-transit	icai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):		
the attending ph	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
been signed by should be detac	by	Part II. Other significant conditions con	ntributing to death but not resulting i	n the underlying cause given in Part I.		use contribute to the cause of death
ate has	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause death? 1 ☐ Yes 2 ☑ No
	To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 N = R/Ou	Others	ath (Check only one) Home 5 Residence	0 FOther (0 1/1)
n. After th funeral	Certification: T	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury 28b.	Time of injury at Work? M 1 Yes 2 No	28d. Describe how inju	
within 24 hours after deat To the Funerel Director: completely filled in by the		4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At home, fabuilding, etc. (Specify)	a death occurred at the time, date and place	City or Town, Star	and manned as stated
n 24 n ne Fur pletely	edical	(Check only 2 Medical Examination)	ner: On the basis of examination are and manner stated.	nd/or investigation, in my opinion, death occ	urred at the time, date ar	d place, and due to the cause(s)
To th	Me	296. Signature and title of certifier	in a my Dy	29c. License number ME D3147 (Type, Print) Hernlock Cene u		ate signed (Month, Day, Year)
3 1						

			For	State of Marylan			of Health and	•	e a a a	
			- State AMEND ITEM #		9/04 Gert	ificate	of Death	Reg. N	. 200	
	Physicia	an	1. Decedent's Name (First, Middle, Las	r) G-			NILKINS	2. Date of Death Month D	ey Year	3. Time of Death
,	/Medic	_	LAKRAMON 4a. Facility Name (If not institution, give			4b. City, 7	Town, or Location of Death		c. County of Dee	1 1 2
	LXamii		JOHNS HOPKINS	HOSPITAL			TIMORE CI		NIA	
	Funeral		5. Social Security Number 6. Se 544-69-5757	7. Age (In yrs.	yrs.	If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Year	1049 Ng	rthplace (State or Foreign ountry) QSD D C
7	Director		Usual Residence of Decedent					JULY	773 00	
achae	ehow	7	10a. State 10b. County		y. Town or Loca					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
the M	28a-f	recto	10e. Street and Number		-1717101	10f. Zip	Code	10g. C	itizen of What C	ountry?
dien de	lal Hygiene. Ial Hygiene. d other than "natural", or Itams 23s or 28s-f show event, the Medical Exeminer must be notified at	Funeral Director	5221 Linden 1	leights Ave.		2	1215	U	SA	
	Itams Der m	uner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	S. 13. W	as Deced Yes, spec	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
036	illed Willist 72 hours aries Hygiene. other than "natural", or Ita ent, the Medical Exemins	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1[Yes 2	No Specify:		Specify: B	lack
۲ د	natur	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decede (Give k	ind of wor.	k done during most of wor	king 16b.	Kind of Business	s/Industry
121	than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		onotus ectic		cer S	State	
פר	ital Hygind other	Be C	17. Father's Name (First, Middle, Last)	11/1:				ne (First, Middle, Maide	n Sumame)	
Maryland 21215-0036	Men	10	Thomas G. Wi	IKINS	405 14-11		Kegina	P. Burr	<u>119</u>	Tin Codel
Mar	a tra		19a. Informant's Name/Relationship (1	ins - 11/1 FD.	522	Address	(Street and Number or Ru	its Ave. 8	valto V	nd 21215
ore,	of Healt f Item 2 r other		20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cramation 3 ☐		lace of Disposi	ition (Nama	ne of	Date 20c.	Location - City or	r Town, State
Baltimore,	ment of tank: If the tank: If the tank or o		* 4 □ Donation 3 □ Other (Specify) Dam	ison tores	t Veter	ansternatory 3/3	1104 DW1	793 Mils	mD
Bal	permit. rages Department of Important: If I eny injury or once.		21. Signature of Experal Service Licen	See Jane	Gr	Name and	Address of Facility March FIH	a to Fred	nilton	21239
	5 A		23a. Part1 Enter the disease, or com shock, or heart failure. List only	olications that caused the deat	h. Do not enter	r the mode	of dying, such as cardiad	or respiratory arrest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	a INTERSTI-	TIAL	LUN	JG DISEAS	SE		Onset and Death
7.1	/Medical Examiner		1630 mily	Due to (or as a conseq	uence of):					
X.		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conseq	uence of):					
	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a conseq	uence of);					
760,	icate be executed physician and s the burial-transit	cai E		d						
	ng phy as th	_	IF FEMALE:							
Вох	eath certific attending pl	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnated 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3 ☐ E	Ectopic pro			23d. Date of de Month	Day Year
0	by the ached	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		0.110. (4)				
Division of Vital Records, P.O.	Attending Physician: The law requires that the death Certifica death. ector: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as the	Ď	Part II. Other significant conditions of	ontributing to death but not res	ulting in the und	derlying ca	ause given in Part I.	23e. Did tobacco		robably 4 Unknown
ord	w require been sig	eted						24a. Was an		autopsy findings available
Rec	ne law e has age 2 a	Completed						autopsy performed?	prior to death?	completion of cause of
[a]	ician: In certificate ector, pag	BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ☐ ↑ ath (Check only one)	10 10 10	S 20Bileo
> >	Physica this ce al direc	2	examiner? 1 Yes 2 No		ER/Outpatient			lome 5 Residence		ecify)
ouo	After t	tion:	27. Manner of Death t Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	м 2	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred	
Visi	or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		ome, farm, stre	et, factory		28f. Location (Street City or Town, Sta		Rural Route Number,
٥	urs after real Direction by									
	To the Hospital or Attending Prysicien: The within 2 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		nysician: To the best of my kno niner: On the basis of examina and manner stated.						
	To the Hospital within 24 hours a To the Funeral Completely filled	Me	29b. Signature and title of certifier	Vin			. License number	29d. C	Date signed (Mon	nth, Dey, Year)
	X		I genrefer J.				ES-000	MAR	RCH 2	5 2004
	11		30. Name and address of person who 660 NORTH	completed cause of death (Iter		_	IMORE	MARULANT) a <i>l</i> a	287
	Sta		31. Date filed (Month_Day, Year)	32. Agistrar's Signa	ature					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MONTARCH Day 8, 2004 **Physician** 3:36 Vincent J. Weigman, Sr. /Medical 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1**X**M 2□F 83 Director June 7 1920 MD 215-05-0009 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show oldes Examiner must be notified at 1 Yes 2 No Director MD Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12108 Tullamore Ct. #103 21093 USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hygiene. and Health and Mental Hygiene. It is marked other than "natural, or ite ury or othar traumatic event, It a Modical Exercite ury or othar traumatic event, It a Modical Exercite ury TYes 2 □ No IYes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white Specify: 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President of Bachrach Sporting Goods 12 n/a Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Weigman Marie Lepson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eleanor S. Weigman/wife 12108 Tullamore Ct. #103, Lutherville, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if ite
any injury or ot
once. 3/31/04 1 Surial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Memorial Gardens 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Servi Michael J. Ragle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** resulting in death) /Medical Due to (or as a consequence of): PNEUMONIA **Examiner** DAYS Sequentially let conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed LYMPHOMA YEARS and resulting in death) Last physician and the purial-tr Due to (or as a consequence of): by Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No detached o 9 Unknown 9 Unknown þ ď The law requires that signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 × No 1 Tes 3 Probably 4 Unknown RENAL FAILURE Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CARDIOMYOPATHY has page 2 autopsy performed 1 ☐ Yes 2 No certificate Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D31826 3-28-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE TOWSON MARYLAND 21204 RICHARD LINTHICUM M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Dacks! Registrar

Physician Medical Examiner 1. Decedents Name (First, Middle, Last) 2. Date : Month MAK A. Facility Name (If not institution, give street and number) VINVESTY OF HARYLAND MEDICAL SYSTEMS Social Security Number : 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of (Month Nov 100. City, Town or Location of Death Month Nov 100. City, Town or Location	Day Year 22 2004 11:40 M
Funeral Director Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date 220-22-7593 1 m 2 m 2 m 5 86 Yrs. Months Days Hours Min. Nov Months Days Hours Min. Nov Min. Nov Months Days Hours Min. Nov Min.	4c. County of Death
Usual Residence of Decedent 10a. State 10b. County MD Baltimore Timonium 10c. City, Town or Location Timonium 10d. State 10d. Sta	of Birth Day, Year) 9. Birthplace (State or Foreign Country)
Aloysius Joseph Walsh Page 19	10d. Inside City Limits 1 ☐ Yes 2♥ No
Aloysius Joseph Walsh Page 19	10g. Citizen of What Country? USA or No- 14. Race - American Indian, Black, White, etc.
Aloysius Joseph Walsh Page 19	Specify: White 16b. Kind of Business/Industry
20a. Method of Disposition 20a Date	· ·
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator	umber, City or Town, State, Zip Code) • MD 21286
23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator	20c. Location - City or Town, State
Physician /Medical Examiner Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. They, reading to immediate.	
So the state of th	23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. C	Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
	Vas an utopsy and 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner? 1	
City or	on (Street and Number or Rural Route Number, Town, State)
The state of the s	ne, date and place, and due to the cause(s) 29d. Date signed (Month, Dey, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WEN-YEE TSA! 22 SOUTH (DIEFNE STREET BALTIMOVE MD 2 State Registrar MAR 3 0 2004	MAR 22. 2004

			For State			partment of He			jiene leg. No. 20	Ω Ι.	00000
			1 - State Registrar AMEND ITEM #8	PER FH G830	3//2/04 51	erinicate of D	eaur	2. Date of Dea		U¥	3. Time of Death
	Physicia /Medic		Samue	_	Yeatts	Wils	on	March 2		Year	4:35 p ^M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Lo	ocation of Death		4c. County o		
			Carroll Hospita		/f f 6 \ 6		inster Under 24 Hrs.	9 Date of Birth		roll	lece (State or Foreign
	Funeral Director		5. Social Security Number 6. Se 12 18-01-9981	MM 20 E	(In yrs. last birthda 89 Yrs.		Hours Min.	8. Date of Birth (Month, Day MARCH 01,	, Year)	Coun	try)
	ਹੁ		Usual Residence of Decedent					I A II CAT OI 5			
	anylar ehow	_	10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	Director	MD Baltim	ore		Reisterst	own	1	I0g. Citizen of Wi	nat Coun	
	with Sa or	٥		Hanover R	oad	211	36			S.A.	,
	death	Funeral	11. Marital Status	12. Was Decedent E		3. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Sc	ecify Yes or No-	14. Race		an Indian,
9	s 1 and 2 should be fited within 72 hours after death with the Maryland I health and Mental Hygiene. I health and Mental Hygiene. The show items 23s or 28s-f show other than "natural", or items 23s or 28s-f show other traumatic event, the Madical Examiner rust be notified at	by Fur	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:			Specify:	nican, etc.)	Specify:		
Ś	hours tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu		16a. De	cedent's Usual Occupati	on		16b. Kind of Bus		ite dustry
2	hin 72 9. Nedit	Completed	(Specify only highest grad		life	ve kind of work done du a. DO NOT use retired)	ring most of work	ting			
V	buld be filed with Mental Hygiene. arked other than atic event, the Maric event.	Соп	12			District Man			Suburba		opane
2 2	be fits Hy of the oct	Be	17. Father's Name (First, Middle, Last)	-		1	8. Mother's Nam		Maiden Sumame		
Ž	should be nd Mental marked c	ဥ	Andrew S. Will 19a. Informant's Name/Relationship (T)	lson	19h Ma	ailing Address (Street an	d Number or Ru			aton	111
2	and 2 sho ealth and n 27 is m		Ruth W. Wilson	Wife		14 Old Hanov					
ນົ	s 1 and 2 f Health item 27 other tra		20a. Method of Disposition		20b. Place of Dis	sposition (Name of rematory or other place)		Date	20c. Location - C		
<u> </u>	Pages nent of int: If it iny or o		1 ⊠ Burial 2 ☐ Cremation 3 ☐ I 14 ☐ Donation 5 ☐ Other (Specify,		1	n Mem. Park)4 1	Finksbur	g, M	aryland
Daltillion	permit. Pages 1 and Department of Heali important: If item 2 ony injury or other ance.		21. Signature of Funeral Service Licens	0		22. Name and Address	of Facility 11		sterstow		
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do not	ELINE FUNERA enter the mode of dying,			rstown,	МПО	21136 Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition			Acryt	hymin				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	Arryt		// /	0.		
	Lxammer	16	Sequentially list conditions, if any, leading to immediate	D	consequence of):	f/c (.010)	n7 (1-1 2-1-1	Wile	. 5 4	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (01 402							
Ď	icate be executed physicien and s the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of):						
0/00	ohysici the bu	dlcal	(d							
×	certific ding p	lan/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy				23d. Date	ol delive	10/
DO	death certifi attending of for use as	O	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			Mon:		Day Year
S	that the de ned by the a detached f	Physi	9 Unknown	9□ Unknown							
ds, r	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	by	Part II. Other significant conditions of	intributing to death bu	t not resulting in the	e underlying cause given	in Part I.				ably 4 Unknown
cords,	w requ	lete						24a. Was a	an 24b. W	ere auto	psy findings available
ð	sician: The law certificate has l irector, page 2 s	Completed						autop: perfor	med? _ de	ior to cor eath? ⊒ Yes	npletion of cause of
VIII		BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only or			
> 10		70	1 ☐ Yes 2 ☑ No	Hospital: 1 Impatier		tient 3 DOA Other	4 Nuising H		ence 6 Othe		<i>(</i>)
	0 0 0	lon:	27. Manner of Death 1	28a. Date of Injury (Month, Day	y 28b. Time Year) Injur	y Work?	it os 2 □ No	28d. Describe h	ow injury occurre	d	
UIVISION	or Attending after death. I Director: After d in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju		street, lactory, office	1		treet and Numbe	r or Rura	I Route Number,
5	- e	Certi	4 Homicide	building, etc	. (Specity)			City or Tow	n, State)		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (examination and/or	eath occurred at the time r investigation, in my opin					
	o the o the omple	Med	29b. Signature and title of certifier	and manner sta	180.	29c. License	number	2	29d. Date signed	(Month,	Day, Year)
•	⊢ s ⊢ δ		I Parto 2.	Mon,	uno	033	802		3/29	10	7
	13		30. Name and address of person who o	completed cause of de	eath (Item 23a) (Typ						
	\"		31. Date filed (Month, Day, Year)			nell Le	~ F	Urist	15001	and for	oun 1013 21176
	Sta Registr		MAR 3 0 2004	Sen va	r's Signature	Some					

DHMH 17 Rev 1/2001

ORIGINAL

				For State Registrar	loude	State o	f Marylan	-	artmen rtificat				lental Hy	giene Reg. No	2004	09830
		Physicia	an	1. Decedent's Name (First, Seou		ast) Hwa Yo	10						2. Date of De		^y 2004 ^{Year}	3. Time of Death 7:40am M
		/Medic Examin		4a. Fecility Name (If not inst					4b. City,	Town, or	Location	of Death		4c	. County of Death	
				Gilchrist Ho			7	1 1	If Under		SON	24 Hrs	9 Data of Sig		Baltimor	
	·	Funeral Director		5. Social Security Number 130-42-3856		Sex 1X M 2□F	7. Age (In yrs. 69	-	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Sept.	30°,	1934 K	place (State or Foreign ntry) Orea
5		and *		Usual Residence of Decede			10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
M9 04: 4		Maryla	tor			gomery			ndy S	prin	g					1 ☐ Yes 2 No
1		with the Maryland sa or 28e-f ehow	Funeral Director	10e. Street and Number 19234 Chand	lee 1	Mill Roa	d		10f. Zip	208	60			10g. Cit	tizen of What Cou USA	ntry?
		death	nera	11. Marital Status		12. Was Dece	edent Ever in U	.S. 13.	Was Dece	dent of Hi	spanic Or	igin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Ameri Black, White	
40.	980	within 72 hours after death ene then "neturel", or Items 23 the Medical Exarciner Itiua		1 Never Married 2	-		2 ∏X No ⁄e	-	1 ☐ Yes		Specify.				Specify: Whi	
7 7	15-0	"natu	letec	(Specify only	highest g	Education rade completed)		16a. Dece	dent's Usua kind of wo DO NOT u	al Occupa rk done d	ation during mos	st of worki	ing	16b. K	ind of Business/Ir	dustry
i	21215-0036	d withing giene	Be Completed by	Elementary/Secondary (0	-12)	College (1	I-4or 5+)	Board						H	ealth Ca	re
	Maryland 2	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene item 27 ie marked other then "natural", or items 23s or 28e-f show other traumatic event, the Medical Examiner man be notified at	To Be C	17. Father's Name (First, M Nyung		oung Yoo							(First, Middle, - Ducks		Sumame)	
57	Aary	12 shour and North terms		19a. Informant's Name/Rel											or Town, State, Zij ring, MD	
200		ss 1 and 2 of Health in the 27 is other tre		20a. Method of Disposition			20b. F	Place of Dispo) Sand	_	ocation - City or T	
SEOUN	altimore,	nit. Page partment o cortant; if injury or		1 X Burial 2 ☐ Crema '4 ☐ Donation 5 ☐ Ott	ner (Spec	cify)	State					3/30	/2004	Mar	riottsvi	11e, MD
00,	Balt	permit. Pages Department of the Important; if its any injury or or or once.		21. Signature of Eyneral Se	n	Q. Ha	rest								PA (Box 5-1400	195)
7	100	Physician		23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition	se, or co . List on		aused the deat each line.	h. Do not ent		de of dyin		cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
		/Medical Examiner		resulting in death)	1	Due to	(or as a consec	juence of):)
		led sit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	b. Sue to	(or as a cor sec	uanoa ul):								
	,092	le be executed ysician and e burial-transit		that initiated events resulting in death) Last		c. Due to	(or as a conseq	juence of):								
	687	9 8 9	edical			d										
	P.O. Box (ne death the atte	by Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown		1 ☐ Live t	tcome of pregnation 2 Tetal Fe	al death 3	⊒Ectopic p ⊒ Other (sp						23d. Date of deliv Month	ery Day Year
		uires that the signed by the detaction in the detaction in the detaction in the detaction in the signer in the sig		Part II. Other significant co	onditions	contributing to d	eath but not res	ulting in the u	inderlying o	cause giv	en in Part	l.	3	obacco Yes 2		he cause of death?
	Division of Vital Records,	The law requir ate has been s page 2 should	Completed										24a. Was auto perio 1 Yes		prior to co	opsy findings available impletion of cause of
	ital	sician: Tector, prince	Be C	25. Was case referred to mexaminer?	edical							e of Death	(Check only	/	/	
	n of V	ding Physic h. After this ce funeral dire	2	1 Yes 2 No 27. Manner of Death 1 Notatural 5	Pending	28a. Date (Mon		28b. Time o Injury	of :	28c. Injun Wor	y at k?		me 5 Resi 28d. Describe		occurred	who pice
,γ)ivisio	To the Hospital or Attendivillin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ 0	nvestigat Could not determine	be 28e. Place	of Injury - At hing, etc. (Speci		M reet, factor		Yes 2□	-	28f. Location (City or To	Street ar wn, State	nd Number or Rur e)	al Route Number,
		Hospitel 24 hours a Funeral I	Medical Ce	(Chack only 2 7 Mg	dical Cy	aminar: On the h	anie of avamin	ation and/or in	wantingtion	in my o	ninion de	ath occurr	ed at the time	data an	and manner as d d place, and due t	a the equec(c)
_		To the within 2 To the comple	Mec	29b. Signature and title of	certifier /	1	5. 5.0104		29	c. Licens	e number			29d. Da	ite signed (Month,	Day, Year)
		5		MACL		llun	9	- 22c) (T -	Brien)	190	350	3		Mo	rch 27	72009
	_	/		Ju. Name and address of p	Van	CS W	CCO	(N (The	rles	B	alto	nme u	Q	21204	
		Sta Regist	ate rar	29b. Signature and title of the second of th	1 0 2	004	Registrar's Sign	avure And	sull.							

04- AKG	2146		For Unper	nd Item#23a	State of M	aryland / De er ME,6830,2	partment of H 123/04eg entificate of	lealth and Death	Mental Hy	giene (, Reg. No.	2004	09831
			Decedent's Name		(t)				2. Date of D		Year	3. Time of Death
	Physicia /Medic		Josh	M.	Zolma	n			March	28, 2	2004	4:38 A M
	Examin				street and number)			r Location of Dea	th		County of Death	
- 4			North A 5. Social Security N	Arundel H		e (In yrs. last birthda	Glen B		s. 8. Date of B	rth	Anne Aru	place (State or Foreign
3	Funeral Director		216-17-4		X 0 M 2□F	28 yrs.	Months Days	Hours Min	. (Month, D	e <i>y, Y</i> eer) 5 197	Cou	MD
7			Usual Residence of			T.0. 0: 7						10d. Inside City Limits
	ehow	٦	Manuland	10b. County	e Arundel	10c. City, Town or		sadena				1 Tyes 2 X No
	ith the Marylar or 28a-f ehow	Director	Maryland 10e. Street and Nur		Alunder		10f. Zip Code	Jaacha		10a. Citiz	en of What Cou	intry?
	with Be of	٥		lest Shore	Poad			21122			USA	
	ms 23	nera	11. Marital Status	C3C 31101 C	12. Was Decedent	Ever in U.S. 1	3. Was Decedent of H If Yes, specify Cub		Specify Yes or N	0- 1	4. Race - Amer Black, White	ican Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural; or Items 23e or 28a-f ehow other traumatic event. The Medical Exameted rinust be invitted at	by Funeral	1 Never Marr	ied 2 Marned 4 Divorced	Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No				Specify: W	hite
5-0	72 h "natu	Be Completed	(Spec	15. Decedent's Ed cify only highest gra	lucation de completed)	16a. De	cedent's Usual Occup ive kind of work done b. DO NOT use retire	oation during most of wi	orking	16b. Kin	nd of Business/li	ndustry
121	within ene. than	dmo	Elementary/Seco	ndary (0-12)	College (1-4or	5+)	Manager				ant	
9	filed Hygi other	e C	17. Father's Name	(First, Middle, Last)		1	Hanager	1 -	ame (First, Middle			4110
lan	fental fental rkad rkad tlc ev	To B	Georg	e R.	Zolma	n		Nancy	Κ.	Z	olman	
lary	and Men s marka numatic			ame/Relationship (ailing Address (Street					
≥, ≤	and lealth m 27 hsr tr		Kelly E.		(spouse		23 West Sh				oation - City or T	
Jore	iges 1 of H or of or ot			Cremation 3	Removal from State	·	sposition (Name of trematory or other pla		ril 01			
Iţi	Baltimore, permit. Pages 1 ar Department of Heal Important: If Itam: any injury or other once.			5 Other (Specification Service Line)	/ \	Gien Ha	ven Cemete 22. Name and Addre	4	2004 Stal			, Maryland 1 Home, P.A
Ba	Depa Impo any ir			. 2.5	21		3111 Mour					
Į.			23a. Part . Enter t	he disease, or com	plications that cause	d the death. Do not	enter the mode of dyl					Approximate Interval Between Onset and Death
68760,	Medicate be executed Examiner as the burial-transit	dical Examiner	resulting in death) Sequentially list come any, leading to incause. Enter Under Cause (Disease or that initiated event resulting in death)	injury s	b. Sue to (or as	a consequence of): a consequence of):						
P.O. Box 6	Attanding Physician: The law requires that the death certifica obath. sotor: Affer this certificate has been signed by the attending phy the funeral director. page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	! months?		e of pregnancy 2 Fetal death at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		2	3d. Date of delin Month	very Day Year
	es that igned b	y Pt	Part II. Other signi	ficant conditions	contributing to death	but not resulting in th	e underlying cause gr	ven in Part I.	23e. Did	tobacco u	se contribute to	the cause of death?
Division of Vital Records,	w requires been sign should be					,			1 🗆	Yes 2	∃No 3⊟Pro	bably 4 Unknown
ecc	e law re has be je 2 sh	ompleted							24a. Wa aut	opsy	prior to c	opsy findings available ompletion of cause of
<u>=</u>	: The	Con								formed? 2 ☐ No	death?	2 No
VIE	sician: Th certificate rector, pag	o Be	25. Was case refe examiner?		Hospital:	a[[5][0]	20 DOA ON	her	eath Check only			
of	ding Physician: The la'h. h. After this certificate has funeral director, page 2	-	1XX es 2 2 27. Manner of Dea		1 ☐ Inpat	ury 28b. Tim	e of 28c. Inju	4 Nursing	Home 5 Re			ny)
ion	nding ath. r: Afte	atlo	1 □Natural 2 □ Accident	5 Pending investigatio	1 CULIES /20 //	Y Yeer) found	3:40a+ 1	Yes 2XXNo	unknown			
Vis	r Atts er deg recto	Certification:	3 🗍 Suicide 4 🗌 Homicide	6 Could not be determined	e 28e. Place of Ir building, e	njury - At home, farm	street, lactory, office		City or T	own, State)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Cer			tound: res	sidence			-	runde	County,	idena, Anne Ma ryland
	Hosp 24 hou Fune Itely fi	edical	29a. Certifier (Check only one)	1∐ Certifying Pl 2√Medical Exa	nysician: To the bes miner: On the basis and manner s	of examination and/o	eath occurred at the t r investigation, in my	ime, date and pla opinion, death oc	ce, and due to th curred at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and	title of certifier		10	29c. Licen	se number		29d. Date	e signed (Month	. Day, Year)
	F \$ F 0		De St	12/2	~//	$V \setminus$	O.C.M	.E.		Mar	ch 29, 2	2004
			30. Name and add	ress of person who	completed cause of	death (Item 23a) (Ty	pe, Print)					
	411		5, 1	K. HOX	MAN		111 Pen	n Street	, Balti	nore,	Maryla	nd 21201
	Sta Regist		31. Date liled (Mo		32. Regis	trar's Signature	,					
Di	HMH 17 Rev 1/2		MAR.	3 0 2004	Denew	N G	sparks					
01						ORIG	INAL					

10d. Inside City Limits 1 ☐ Yes 2 🗓 No

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09832 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 25 :25 0 - 04 James .3 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner GENESIS ELDERCARE-HOMEWOOD BALTIMORE If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) MARCH 2 1911 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months VIRGINIA 93 220-05-2719

10c. City, Town or Location

Director

Usual Residence of Decedent

10b. County

10a. State

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23a or 28a-f show any Injury or other traumetic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Physicia /Medica Examine

within 24 hours efter deeth.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

٤	MARY	YLAND B	ALTIMO	RE CO	Í	ROS	SEDALE						1 □ Ye	es 2.[XNo
Director	10e. Str	reet and Number	.,					Zip Code			10g. Citizen of	What Cou	intry?	
2	3 6	6810 BENS	EL AVE	NUE				2123	37		U.S.A	١.		
Ermorel	11. Mar	rital Status		12. Was Decedent i	Ever in U,	S.	13. Was Dec	cedent of H	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No	- 14. Ra	ce - Ameri	ican Indian,	
ū	10	Never Married 2[☐ Married	1 ☐ Yes 2X N	10				Specify:	to ricall, etc.)		ack, White,	•	
Ž	3/07	Maxidowed 4 □ Di	vorced	Year or Dates:			ILI Yes	2423 110	Specify:		Speci	ity: BLA	ACK	
Completed			ecedent's Ed	ucation de completed)		16a. I	Decedent's U	sual Occup	ation	rkina	16b. Kind of I	3usiness/Ir	ndustry	
1	Elem	entary/Secondary (College (1-4or 5	i+)	- 1	life. DO NOT	use retired	during most of wo	3				
٥	2nd	d grade				LAE	BORER				STEEL			
ď	17. Fath	her's Name (First, A								me (First, Middle,	Maiden Surna	me)		
F	P	ANDREW AM	OS						ELLE	N OLIVER				
	19a. Inf	formant's Name/Re	lationship (7	ype, Print)		19b.	Mailing Addre	ess (Street	and Number or R	ural Route Numb	er, City or Town	ı, State, Zij	p Code)	
		nald T. A		n					RD., BA	LTIMORE,	MARYLA	ND 23	L216	
	20a. Me X∂	ethod of Disposition	ntion 2 🗆	Removal from State	20b. Pl	ace of l metery	Disposition (A r, crematory o	Name of or other plac	:e)	Date	20c. Location	- City or T	own, State	
		Donation 5 0			HO	LLY	HILLS	MEMOF	RIAL	03-30-04	MIDDLE	RIVE	R, MAI	RYLAND
ġ	21. Sign	nature of Funday	Arylice Ricery				22. Name	and Addres	ss of Facility	ONANTINI TITISE	DIINID A	T IION	(T D :	7
3		///	The state of the s	Waren !					RTH AVEN	OMMUNITY	FUNERA	T LON	TE P.F	4.
	23a. Pa	arty. Enter the dise	ase, or comp	lications that caused one cause on each lir	the death	. Do no	1				rrest,		Approxim	ate
	sn	nose or heart failur	e. List only o	one cause on each iir	10.							1	Interval B Onset an	etween d Death
		iate Cause (Final			(0,5	010					I I		
r	resultin	e or condition og in death)		e	د_ Due to (or	2526	onsequence of	nf)·				i		****
ةِ 🗕					D20									
Examiner	Seguen	ntially list conditions		b. ————	Due to (or		onsequence o							
		leading to immedial Enter Underlying (Disease or injury	te	_	Do		An.	n.						
3	Cause that init	tiated events	~	C	Due to (or	as a co	insequence o	f):						
3	resulting	ig in death) Last										i		
1				d										
Completed by Physician/Medical	Part II. C	Other significant c	onditions co	ntributing to death bu	ıt not resu	Iting in	the underlying	g cause give	en in Part I.	23b. Did 1	lobacco use ci	ontribute t	o the caus	e of death?
Š	T	0- 0.		1 0 0 0 0		1		1	0	10	Yes 2 No	3□ Pro	bably 4	Unknown
2	1	6000160	4	llers	7	Ux	warn	tra	es					
7	T	· last mas			ĺ)		24a. Was	an autopsy rmed?	av	ere autops ailable prio	or to
<u> </u>		MERION										CC	ompletion of death?	f cause
5										101	res 2 No	11	☐ Yes 2	₽ No
Be C	25. Was	s case referred to n	nedical						26. Place of De	ath (Check only o	ne)			
<u> </u>	exam	miner?]Yes 2⊒H0		Hospital: 1 ☐ Inpatie	nt 2 🗆 i	ER/Outp	oatient 3□ l	DOA Oth	er: 4 Nursing I	lome 5 ☐ Resid	dence 6 □Ot	her (Speci	fy)	
		nner of Death	D 17	28a. Date of Injur (Month, Day	y (Year)	28b. Ti	me of ury	28c. Injury Work	at	28d. Describe h	now injury occu	rred		
atio	2	Accident	Pending investigation			,	М		Yes 2□No					
lific	3 🗆		Could not be determined	28e. Place of Injubuilding, etc	ry - At ho	me, farr	n, street, fact	ory, office		28f. Location (S City or Tox	Street and Num	ber or Rura	al Route No	ımber,
اخ				Daniality of	(0,000)	,					,,			
163	29a. Ce	ertifier 1 4 Co	ertifying Phy	sician: To the best of iner: On the basis of	f my know	rledge,	death occurre	ed at the tim	ne, date and place	and due to the	cause(s) and m	anner es s	stated.	2(c)
Medical Certification:	OI	ne)	pulcal Cadili	and manner sta	ted.	on and	OI IIIVestigati	on, in my op	Jillion, death occi					
2	29b. Sig	gnature and title of	certifier	1			2	29c. License	e number		29d. Date signe	∍d (Month,	Day, Year)	'
		•	MA	~				D	60530	1	3-2	5-1	54	
	30. Nam	ne and address of p	person who o	ompleted cause of de	eath (Item	23a) (T	ype, Print)			1 wite 30	R	alta	mond	
	Wije	ay R. H	ezde	MD3	821	N	· Eut	ww	Sty S	wite 30	3 1		21	201
tate	31. Date	e filed (Month, Day,	1	32. Agistra	r's Signat	ure	hout	1)	*					
trar		MAR	3 1 20	JU4 Alas	100	S	ALC: NO.							

DHMH 16 Rev 6/95

State Registrar

			1 - For State Registrar	State of Maryland		epartment of He			giene Reg. No.	2001	0983
H	12.5		1. Decedent's Name (First, Middle, La	st)				2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		William G. Alle	n				March			11:35 PM
	Examin		4a. Fecility Name (If not institution, giv			4b. City, Town, or Lo		h	4c.	County of Deeth	
			4001 Dorchester 5. Social Security Number 6. S		act hirth	Baltim	nore If Under 24 Hrs	A Date of Bir	th	0 Birthe	place (State or Foreign
	Funeral Director			1⊠M 2□F 83			Hours Min.	8. Date of Bir (Month, Da Apr 22	y, Year)	20 Nort	place (State or Foreign ntry) h Carolina
			Usual Residence of Decedent						,		
	nylan how	_	10a. State 10b. County MD			or Location More				1	10d. Inside City Limits
	8a-f	Director							10 00		1∑Yes 2☐No
	with the		10e. Street and Number 4001 Dorchester	Pond		10f. Zip Code 21207	7		10g. Citiz	zen of What Cour	ntry?
	death with the Maryland me 23a or 28a-f ehow Finast ke niktiffed at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	S.			pecify Yes or No	- 1	USA 14. Race - Americ	can Indian,
0	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "naturel", or Iteme 23a or 28a-f ehowevent, the Medical Exacilitier must be neitified at		1 Never Married 2 Married	Armed Forces? 1. ⚠ Yes 2 ☐ No		13. Was Decedent of Hisp If Yes, specify Cuban,		to Rican, etc.)	Ì	Black, White,	
2-0030	ould be filed within 72 hours after. Mental Hygiene. arked other than "natural", or Ite atic event, I'm Medical Exacilina	1 by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates: 143-	46	1 ☐ Yes 2X No	Specify:			Specify: bl	ack
'n	72 h	Completed	15. Decedent's E (Specify only highest gra		16a. l	Decedent's Usual Occupation (Give kind of work done dur (life, DO NOT use retired)	on ring most of wa	rking	16b. Kir	nd of Business/In	dustry
7	within ane. than	m m	Elementary/Secondary (0-12)	College (1-4or 5+)		cook				food	
N D	Hygir Hygir Sther	a	17. Father's Name (First, Middle, Last)			8. Mother's Nar	me (First, Middle,	Maiden .		
land	Mental Mental Med of	To B	Fred Allen				Mary	Belle C	olsor	ı	
Mary	12 should be filed within 7 n and Mental Hygiene. 7 is marked other than " reumatic event, the Med	-	19a. Informant's Name/Relationship (• • • • • • • • • • • • • • • • • • • •	19b.	Mailing Address (Street and	d Number or Ru	ural Route Numb	er, City or	Town, State, Zip	Code)
-	l and 2 tealth im 27 I		Sarah Hall/niece			001 Dorcheste	r Road				
Baitimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special	Removal from State	lace of emetery	Disposition (Name of r, crematory or other place)		Date	20c. Lo	cation - City or To	own, State
Dall	permit. Pages Department of I Important: If ite any injury or of		21. Signature of Euneral Prvice Lice Ron d S.	Wade, Director		State Anator Baltimore, N	of Facility My Boar MD 212	d 655 W.	Bal	timore S	Street
	Physician /Medical Examiner		23a. Pan 1. Enter the disease, or compose, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that caused the death one cause on each line. a	(11	Artery o	such as cardia USEC-		rrest,		Approximate Interval Between Onset and Death
Ш	p is	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a consequ	uence o	n.					
8/60,	eath certificate be executed attending physicien and for use as the burial-transit	al Examine	that infliated events resulting in death) Last	C. Due to (or as a consequ	neuce o	n):					
/89	icate phys s the	dical		_ d							
C. Box	0 0	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de	death	3 Ectopic pregnancy 5 Other (specify)			2	3d. Date of delive Month	ery Day Year
ds, F.	og og	by	Part II. Other significant conditions	contributing to death but not resu	ulting in	the underlying cause given	in Part I,	23e. Did t		4	he cause of death?
Hecord	> 11 0	lete						24a. Was	an	24b. Were auto	opsy findings available impletion of cause of
	The ate h page	Completed						autoj perfo 1 Yes	osy ormed? No	prior to co death? 1 🗆 Yes	mpletion of cause of
VItal	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	5010	Other		ath (Check only o		-23	
ō	Phys r this sral di	To To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	ER/Out 28b. T	ime of 28c. Injury a	4 Nursing F	28d. Describe		☐Other (Specific occurred	V)
on	Attending Phir death. ector: After thiby the funeral	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	In	jury Work?	s 2 No				
UIVISION	P H F	Certification;	3 Suicide 6 Could not to determined		me, far	m, street, factory, office		28f. Location (. City or To		d Number or Rura	il Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C	29a. Certifier 1 Certifying P (Check only 2 Medicel Exe	hysician: To the best of my kno miner: On the basis of examinal and manner stated.	wledge, tion and	death occurred at the time, Vor investigation, in my opin	, date and place nion, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	tated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	16/1.		29c. License r	number		29d. Date	e signed (Month,	Day, Year)
			30 Name and address of person who	completed cause of death (Item	23a) (Type, Print)	#gng/	Toursen	~ r	ND 21	204
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	44 4110	004	,000			
	Regist	rar	NAT 9 1 2006	berna	19	Spouls					
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				State of Maryland / Department of Health and Me 1- State Registrer Certificate of Death	ental Hygie	2011	09834
					2. Date of Death		3. Time of Death
_		Physici	ian	GEORGE HENRY BERRY SR. Ma	Month	Day Year	7.0 TO M
4		_/Media		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	arch 2	8 2004 4c. County of Deat	10:59 a "
	46	Examir	ner			40. Ocality of Deal	
				HARFORD MEMORIAL HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8.	B. Date of Birth	HARFORD	CO hplace (State or Foreign
		Funeral		1XIM 2 F Months Days Hours Min.	(Month, Day, Yo	ear) Co	nuntry)
7		Director		212-24-8420 78 Yrs. NO	OV 11 19	25 MA	RYLAND
T		and *		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Y		dany f sho	5	MARYLAND HARFORD CO FOREST HILL			1 ☐ Yes 2 🔯 No
0		28e-	ect	MARYLAND HARFORD CO FOREST HILL 10e. Street and Number 10f. Zip Code	100	. Citizen of What Co	unto/2
65:0		ours after death with the Marylan ref; or Items 23a or 28e-1 show Exertifier mast be notified at	Funeral Director		109		unity:
~		8 23	ral	1270 W. JARRETTSVILLE RD 21050	4V N	U.S.A.	don India
2/		er de English	- un	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1☐ Never Married 2★★Married 12. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric	can, etc.)	Black, Whit	
	36	s aft	by F	3 Widowed 4 Divorced Year or Dates:		Specify: BLA	CK
	21215-0036	in 72 hours "neturel", edical Exa		15. Decedent's Education 16a. Decedent's Usual Occupation	161	b. Kind of Business/	
	7.	n 72 "ne	ete	(Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use princil)	7	b. Kind of Business/	industry
5	12	withi ane. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th grade ANIMAL TECH		DGEWOOD A	DCENAT
0	2	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "neturel", or Items 23a or 28e-f show event, the Medical Exertical months to notified a		17. Father's Name (First, Middle, Last) 18. Mother's Name (F			KOENAL
_	an	e d la b	Be	ALDEDE II DEDEN CE			
∞	Ž	should nd Men rmarke	2	ALBERT H BERRY SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural R		its as Taura Chan i	To Code l
70/80	Maryland	s 1 and 2 should be of Health and Menta item 27 is marked other treumetic ex					
0.0	_	1 and 2 Health tem 27		Florence D. Berry/Daughter 1270 W. Jarrettsville 20a. Method of Disposition 20b. Place of Disposition (Name of Date		rest Hill Location - City or	
(1)	ō	Pages nent of h int: If ite		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State	.6 200	. Location - City of	TOWN, State
	altimore	Page Iment tent: I		`4 □Donation 5 □Other (Specify) FAIRVIEW A.M.E. 04-03-			, MARYLAND
	Balt	permit. Pages Department of Importent: If i any injury or once.		21. Signature of uneral Service Licensee WM COMMUNITY	FUNERAL	HOME -HA	RFORD, P.A.
	ш	20E 29		321 S PHILADELPHIA B	BLVD., A	BERDEEN,	MD 21001
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart failure. List only one cause on each line.	espiratory arrest,		Approximate Interval Between
		Physician		Immediate Cause (Final disease or condition			Onset and Death
	4	/Medical		resulting in death) a. Due to (or as a densequence of):			
	п	Examiner					
			ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uisease or injury			
		outed Id	Examin	Cause (Disease or Injury that initiated events c.			
	ó	be executed sician and burial-transit	EX	resulting in death) Last Due to (or as a consequence of):			
	8760,	ate be nysicia he bu	Physician/Medicai	d.			
7	9		edi				
5	Box	eath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of deli	very
0	8	death e atte d for	icia	in the past 12 months? 1 Ves. 2 No. 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
M	0	that the de ed by the detached	hys	9 Unknown	·		
(-1)	σ.	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
01	ds	puire n sign		Pulmollans embolism.	1 ☐ Yes	200No 3□Pr	obably 4 Unknown
2	Record	w rec	Completed	Lionalate. Com	24a. Was an	24h Were au	topsy findings available
sorg	Re	0 5 0	를	00,0000031000	autopsy	prior to d	ompletion of cause of
D	a	T: Tr		- acite Alia facille	1□ Yes 2□	No 1 □ Yes	2 No
CO	Vital	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical accommon 26. Place of Death (Continued accommon 25. Place of De			55000
\bigcirc	o	6 ≠ 10	5	1 Tes 25 No 12 Impatient 2 EH/Outpatient 3 DOA 4 Nursing Home	 5 ☐ Residence d. Describe how in 		sity)
			Ö	Natural 5 Pending (Month, Day Year) Injury Work?	d. Describe now	rijury occurred	
	Sic	or:	ical	3 Suicide 6 Could not be	Location /Stree	t and Number or Ru	ral Pauta Numbar
8	Division	or Attendate death	Certification:	4 Homicide determined 208. Place of multy - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S		rai Houte Number,
1	_	pital urs a erel		Constitute Observation Table based of submiddles doubt	4		
		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		thin in the complete	Mec	29b. Signature and title of certifier 29c. License number	294	Date signed (Month	. Dav. Year)
		F 3 F 8		125360	1	10100. >	9 2006
	7	Ti		rung Junium 077784	1 10	WICO Z	1/
		10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	d		
			l e	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
		Sta Registi		MAR 3 1 2004 Review & Cooks			

			1 - For State Registrar	State of Maryla		partment of ertificate o			g. No.	04 0983
	Physicia	_	Decedent's Name (First, Middle, Las	Josephin	e K. B	risbon		_ Month	Day Yes 200	I L Z O E A
0	/Medic Examin	+437	4a. Facility Name (If not institution, give		- 1 [, or Location of Dea		4c. County of D	
		3		ral Hospi	tal	Balt	in Ure			N/A
100	Funeral Director		231-74-7072	ax 7. Age ∛in y □M 2.DMF	yrs. last birthda 93 Yrs.	y) If Under 1 Yea Months Day		. (Month, Day,	Year) 9. 8	Sirthplace (State or Foreign Country)
g) _	land ow		Usual Residence of Decedent 10a. State 10b. County	10c.	. City, Town or	Location				10d. Inside City Limits
2	rith the Marylar or 28a-f ehow	ctor	Maryland	N/A			Baltimore			1 □ X es 2 □ No
losephine 36	£ 6	Dire	10e. Street and Number 4116 Oakford Ave			10f. Zip Code	21215	10	0g. Citiz <i>e</i> n of What l	Country? J.S.A.
E.	ter death w	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	in U.S. 13	B. Was Decedent o	f Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		mericen Indian,
Jos -0036	urs after al', or ite	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ M			Specify:	Black
	72 hor	Completed	15. Decedent's Ed (Specify only highest gra	lucation de co <i>mpleted)</i>	16a. Dec	cedent's Usual Occ ve kind of work don	supation ne during most of wo	orking	16b. Kind of Busine	ss/Industry
212	d within plene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	. DO NOT use reti	Domestic			Home
Brisbon Maryland 2121	d be filed ntal Hygi ed other	Be	17. Father's Name (First, Middle, Last) Henry	Kendrick			18. Mother's Na	me (First, Middle, M	Maiden Sumame) a Kendrick	
Brisbon Maryland 21215	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hyglene. Important: It item 27 ie marked other than "natural", or it may highry or other traumatic event, the Medical Example once.	오	19a. Informant's Name/Relationship (7	Type, Print)	19b. Ma			lural Route Number,		a, Zip Code)
	1 and Health tem 27		20a. Method of Disposition		b. Place of Dis	position (Name of		ore, Maryland	21215 20c. Location - City	or Town, State
ē	Pages nent of int: It it iry or c		1 Burial 2 Cremation 3 C 1 Donation 5 Other (Specify		-	ematory or other poutus Memor		03/31/04	Balti	more , Md
Baltimore,	permit. F Departmo Importar any injur		21. Signature of Funeral Service Wen	see		22. Name and Add		neral Home P. Baltimore, M	.A.	2
	Physician and Asician and Phys	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	IS Isequence of): My n Isequent e of):	pathy on	ying, such as cardia	ic or respiratory arre	rst,	Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certiticate be eate has been signed by the attending physician page 2 should be detached tor use as the buria	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	egnancy Fetal death 3 of death 5	B⊟Ectopic pregnar 5 ☐ Other (specify)		20. Pilan	23d. Date of 6 Month	Day Year
rds,	w requires the been signer should be d	ed by	Part II. Other significant conditions of	ontributing to obath but not	resulting in the	underlying cause	given in Part i.		s 2 No 3	to the cause of death? Probably 4 Denknown
Division of Vital Records,	sician: The law re certificate has bei irector, page 2 sho	Completed						24a. Was ar autops perform 1 Yes 2	prior t death	autopsy findings available o completion of cause of ? es 2 No
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ou of	ng Phy tter this	tion; To	1 Yes 2 No 27. Mann of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpati 28b. Time Injury	of 28c. In	4 U Nursing	Home 5 Reside 28d. Describe ho		oecify)
Divisio	l or Attendi after death. Director: A I in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, :			28f. Location (Str City or Town		Rural Route Number,
1/2	Hospitel 4 hours Tunerel ely tilled	Medical Co	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my ninar: On the basis of exan and manner stated.	knowledge, de mination and/or	ath occurred at the investigation, in my	time, date and plac y opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the h within 24 To the R complete	Me	29b. Signature and title of certifier		0	29c. Lice	nse number	29	9d. Date signed (Mo	nth, Day, Year)
	6		30. Name and address of person who		(Item 23a) (Typ	e, Print) O	200		1-24-0	<i>T</i>
	Sta	oto-		allero 32. Begistrar's S	MD	. 40	Manj	and G	eneral	Hospital
	Registr		MAR 3 1 2004	Beneva	19 1	parks				

State of Maryland / Department of Health and Mental Hygiene For State RegistramEND ITEM #26 PHR PHY G830 4/16/04 Gertificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 22, Day 2004 **Physician** 9:34 АМ м Emma Viola Brooks /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2008 Star Street Edgewood Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 25, 1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Land **Funeral** 1 □ M 2 🖾 F Months 83 213-20-2712 Director Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow other traumatic event, the Medical Examiner round be notified at 1 Yes 2 No Directo Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 2008 Star Street 21040 USA or Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Black, While, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black 3 XWidowed 4 ☐ Divorced Year or Dates: "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) housekeeper private residences of Health and Mental Hygid Item 27 le marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wesley Williams Druescella Wilmore ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Rumsey/daughter 920 Walker Street Aberdeen, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
ony injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Serv Romald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 nul 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit physician and Division of Vital Records, P.O. Box 68760 Physician/Medicai the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy ģ in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown ۵ signed ! Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been sign. r. page 2 should b 2 2 No 1 Tyes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 The esidence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Many r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title, of certifier 29c. License numbe 29d. Date-signed (Month, Day, Year) 25/14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HD6 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 3 2004

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No.2 () [] 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Albert Blizzard \cap M MARCH 2004 6 4 1:05 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Saint Joseph Medical Center Baltimore Towson If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Dey, Dec /, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 x M 2 □ F 216-16-1054 80 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner roughby notified at 1 ☐ Yes 2√ No Baltimore Towson Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code deeth with 509 E. Joppa Road 21286 or Items 23a USA Funeral 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white ģ 3 ☐ Widowed 4 🗓 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) unk permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If I tem 27 ie marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Many injury or other traumatic event, College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Joseph Medical Center 7600 Osler Drive Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 🛛 Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. War 22. Name and Address of Facility State Anatomy Baltimore, MD Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** HOURS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☐ Unknown DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfori certificate 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation death. M 1 ☐ Yes 2 ☐ No nours after death.

nerel Diractor: A

filled in by the for 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel C To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 04 D 34827 ed dayse of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 7601 OSLER DRIVE, JAMES EBELING, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3cperson Registrar **MAR 3 1** 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** CHARLES T. BALDWIN MARCH 2004 a5 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) June 1, 1 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**∑**M 2□F 87 219-12-6567 1916 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County items 23a or 28e-f ahow the Medical Examiner must be notified at MD Washington Hagerstown 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21742 19800 Tranquillity Circle, Ste. 225 USA by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 X No Specify: White Specify: If Yes, Give Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, Ite Made 2008. Elementary/Secondary (0-12) College (1-4or 5+) Communication Specialist Railroad 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Cornelia Turner Elmer Thomas Baldwin 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Evelyn M. Baldwin/Wife 19800 Tranquillity Circle, Ste. 225, Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Slate Ridge Cemetery 🖯 3/29/2004 21. Signiture of Fungral Service Licens 22. Name and Address of Facility Harkins Funeral Home, Inc.,600 Main St., Delta, PA 17314 spock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician /Medical Due to (or as a cons whence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 : autopsy performed 1□ Yes 2 No Division of Vital 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 1 Ultipatient 3 DOA Certification; To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After To the Hospitel or Attending Injury 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. Director 6 Could not be 3 🗍 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours To the Funeral 1 Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 26/0 € MP 30. Name and address of person completed cause of death (Item 23a) (Type, Print) WAD CESCO ANDRADE 310 31. Date filed (Month, Day, Year) MAR 3 1 2004 3. Registrar's Signature State Registrar

		·	1 - For State Registrar	State of Marylan		artment of H			Reg. No.	. 0200.
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last Daniel Butler 4a. Facility Name (If not institution, give	Street and number)		4b. City, Town, or		2. Date of De Month March	25, 2004 4c. County of D	4:25PM
	Funeral Director		7837 Clark Sta 5. Social Security Number 219-32-3059 Usual Residence of Decedent			Severn If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Bi Min. (Month, Di July 1	Anne A th av, Year) 7,1936	Fundel Birthplace (State or Foreign Country) MD
	hours after death with the Maryland turel', or flems 23e or 28a-f show at Extraitive trust be notified at	Funeral Director	10a. State 10b. County MD Anne Aru 10e. Street and Number 7837 Clark Sta	undel Se	y, Town or Lo	10f. Zip Code 21	144		10g. Citizen of What	Α.
5-0036	72 hours after des natural', or items	by	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced 15. Decedent's Edu		16a. Dece	1 ☐ Yes 2 【XNo	Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - A Black, W Specify:B]	
2121	a filed within Il Hygiene. other than *	Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		kind of work done of DO NOT use retired	Mana		Agency-I	Security Dept.Of Defense
Maryland		₽ C	Howard Butler 19a. Informant's Name/Relationship (7)	,, , ,			and Numbe	r or Rural Route Numb	er, City or Town, State	
	is 1 and 2 should of Health and Men item 27 is marke other traumatic		Nellie L. Butle	20b. P		Clark S estion (Name of matory or other place		on Rd., Se	evern, M. D 20c. Location - City	
Baltimore,	permit. Pages Department of Important: if it any injury or o		1 Surial 2 Cremation 3 4 Donation 5 Other (Specify, 21. Signature of Fune at Service Little)	Mea	adowri	idge Cen	neter ss of Facilit		uneral H	me, M.D. MD 21216
,	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	estil	the Co	10-	Carci	Dags	Approximate Interval Between Quiset and Death
3760,	death certificate be executed as eattending physician and ider use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o		<i>i</i>	26	Caren		2 tyrs
O. Box 6	at the death certifice by the attending pt tached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ds, P.	uires that signed by ld be deta	by	Part II. Other significant conditions co	intributing to death but not res	ulting in the u	nderlying cause give	en in Part I.			e to the cause of death? Probably 4 □Unknown
al Records,	n: The law requires that the ficate has been signed by th ir, page 2 should be detache	Completed						1 ☐ Yes	psy prior death	autopsy findings available to completion of cause of ?
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Divis	i i i i	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death	n occurred at the tim vestigation, in my of	ne, date an pinion, deal	d place, and due to the th occurred at the time,	cause(s) and manner date and place, and c	as stated. fue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MASS	53	29c. License	e number	150	29d. Date signed (Mo	26.2004
	1,8		39 Name and address of person who c	ompleted cause of death (Item	n 23a) (Type,	Print)	1/	Tive Okn	Busnie	hyl. 2/06)
- 0	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 200	32. Registrar's Signa	iture &	poorts	1			

		1 - State Registrar		Maryland / De _l	partment of ertificate o		Re	og. No. 200	
Physic	ian	Decedent's Name (First, Middle					2. Date of Deat Month	Day Yea	3. Time of Death
/Med		Eva	М.		Bivens			29 04	5:15a M
Exami	ner	4a. Facility Name (If not institution Genesis Du		oer)		, or Location of Dea ndalk	th	4c. County of De	
		5. Social Security Number		. Age (In yrs. last birthda			8. Date of Birth	Balt:	
Funeral Director		258-44-0702 Usual Residence of Decedent	1 □ M 2 🔀 F	86 Yrs.	Months Day		Month, Day,		irthplace (State or Foreign Country)
land ow		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
Many	to	Md. Balt	imore	Tur	ner Stati	ion			1 X Yes 2 No
th the	Funeral Director	10e. Street and Number			10f. Zip Code)	10	ng. Citizen of What	Country?
th wil	alD	613 New Pitts	burg Avenu	e	2122	22		USA	
after death w	ne	11. Marital Status	12. Was Deced Armed Ford	es?	. Was Decedent of If Yes, specify Co	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian, nite, etc.
s within 72 hours after death with the Maryland jiene. rithan "natural", or flems 23a or 28a-f ehow the Medical Examination to incities an	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ied 1 □ Yes 2 If Yes, Give Year or Dat	X No	1□Yes 🛣 N	lo Specify:			Black
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ed within 72 hours aft gjene. er than "natural", or t, the Medical Exant	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4	life	re kind of work dor DO NOT use reti	ne during most of wo red)	rking		ŕ
giene giene	E O	9th grade	555g5 (1		mestic			Other Poo	oples Homes
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d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relations Samuel Bivens	hip <i>(Type, Print)</i> Husband		-			City or Town, State	
- m - =		20a. Method of Disposition	IIusballu	20b. Place of Dis	Dosition (Name of	ttsburg F		ner Statio Roc. Location - City of	on, Md. 21222
ages nt of I		1 X Burial 2 ☐ Cremation		ate cemetery, c	ematory`or other p	!		7000 ASS-1	
permit. Pages 1 a Department of Hea mportant: If item any injury or othe	8	' 4 ☐ Donation 5 ☐ Other (S			ount Cem.			Paltimore	
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, <u>ç</u> , 2 8	þ	Part II. Other significant condition	ons contributing to dea	th but not resulting in the	underlying cause	given in Part I.			to the cause of death?
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ysician: Th is certificate director, pag	Be (25. Was case referred to medica examiner?				26. Place of De	ath Check only one		
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Jing After		27. Manner eath 1 catural 5 ☐ Pendir 2 Accident investig	y ·	Injury 28b. Time Day Year) Injury	W	jury at fork? □ Yes 2 □ No	28d. Describe how	w injury occurred	
i digita	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	in 286. Place o	f Injury - At home, farm, ; , etc. <i>(Specify)</i>	street, factory, offic	0	28f. Location (Str. City or Town,	eet a <i>nd Number or F</i> State)	Rural Route Number,
e Hospital 24 hours a e Funeral l	Medical (29a. Certifier 1 Certifyir (Check only one)	g Physicien: To the b Examiner: On the bas and manne	est of my knowledge, de is of examination and/or r stated.	ath occurred at the investigation, in my	time, date and place opinion, death occi	e, and due to the caurred at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
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		Mon	1.00	/	DO	08350	/ /	14004	29 2004
2		30. me and address of person	who completed cause	of death (Item 23a) (Typ	e, Print) Qan	2 4	10-	202 1	29 2004
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		1	For State Registrar	State of M		d / Depa	artmei		ealth an			e 20	04	0984
4	Physicia	an	1. Decedent's Name (First, Middle, Las MARY	BARC	ROF	T				2. Date of Month	D		ear	3. Time of Death 6. 15 A M
	/Medic Examin	er	4a. Fecility Name (If not institution, give	street and number)					Location of C	Dealh		c. County of	Deeth N/A	
	Funeral Director		5. Social Security Number 6. S 212 46 5788 1 Usuel Residence of Decedent	9X 7. Ag □ M 2 X F	56 (In yrs. i	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Min. 8. Date of (Month, Sept.	Day, Year	947	Birthpla Countr Mar	ce (State or Foreign y) yland
e Maryland	Sa-f show	Director	10a. State 10b. County Maryland N/A			y.Town or Lo	ore							d. Inside City Limits 1 ☑ Yes 2 ☐ No
with th	3a or 2		10e. Street and Number 4100 - 6th Stre	et			10f. Z	ip Code 2122	25		10g. C	itizen of Wha	at Countr	y?
1215-0036 within 72 hours after death with the Maryland	jiene. rithan "natural", or items 23a or 28a-f show the Medical Examinat transities notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Decilif Yes, sp		spanic Origin n, Mexican, P Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Black, Specify:	White, et	c.
Maryland 21215-0036 d 2 should be filed within 72 hours af	ene. than "natur na Medical	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12th	lucation de completed) College (1-4or	5+)	life.	kind of w	ork done d use retired	luring most of	f working	16b.	Kind of Busin		istry
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Mar)	th and the state of the state o		19a. Informant's Name/Relationship (Ginn Barcroft		r	19b. Maili	•			or Rural Route Nu. Balt.				code) 1 21225
Baltimore, N	ant of Health at: If item 27 y or other tr		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State	20b. P	Place of Dispo emetery, cre	osition (Namatory or	ame of other plac	e) 3,	Date /25/2004	20c.	Location - Cit	ty or Tow	
Baltir permit. P	Department of Important: If it any injury or one one.		21. Signature of Funeral Service Licer		001	2:	2. Name a	and Addres	is of Facility	Gonce Fi hway B				, P.A. land 21225
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Vita sician:	certificate rector, pag	o Be (25. Was case reterred to medical examiner? 1 Yes 2 No	Hospital:	iont 2	ER/Outpatie	ent 3□ [Oth	D.C:	I Death <i>(Check or</i> ing Home 5 ☐ R		6 COther	(Coocity)	
Vision of Vita	ith. : After this s funeral d	 -	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inj (Month, Da		28b. Time o Injury		28c. Injun Worl		28d. Descri		ury occurred	(Specify)	
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To tha	within To the comple	Me	29b. Signature and title of certifier	17.8				9c. Licens				ate signed (f		
•	X		30. Name and address of person who	completed cause of		n 23a) (Type	, Print)	HAR	BOR	HOSPITA	MAK	2CH 20	+,20	225
	Sta	ate rar	GEORGITNA GEO 31. Date filed (Month, Day, Year) MAR 3 1 21	32 Regis	trar's Signa	alure	LA HA	HOVE	K STRE	EI ISACI	THUR	E, AC	0 21	223

				State State State Amend Items 24a,25,26, Registrar	of Maryla 27,29a pe	and/Depart Dr.,682	artment	of H	ealth a	nd Men	tal Hygi	ene 2 0	04	09842
	ı	Physici		1. Decedent's Name (First, Middle, Last)						2. D	ate of Death		Year	3. Time of Death
		/Medio Examir		Bernadine K. Bowden 4a. Fecility Name (If not institution, give street and	number)		4b. City, 1	Town, or	Location of		LICH	4c. County		12 (18)
,		Funeral		North Arundel 5. Social Security Number 6. Sex		tal rs. last birthday)	Gle		Surn If Under 2	4 Hrs. 8. D	ate of Birth	Ann	9. Birthp	unde l lace (State or Foreign
3		Director		219-30-6524 Usuel Residence of Decedent	6	8 Yrs.	Months	Days	Hours	Min. Ma	y 21,	1935	Penr	nsylvania
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`	9	within 72 hours after death with the Maryland ene. then "natural", or itema 23a or 28a-f show he Medical Ezamirar must be notified at	Funeral Director	Armed	ecedent Ever in Forces? s 2 XNo		Was Decede If Yes, speci			in? (Specify Puerto Ricar	Yes or No- n, etc.)	Blac	e - Americ k, White,	etc.
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Ž	rylar	Men	To	19a. Informant's Name/Relationship (Type, Print)		19h Mailir	no Address	(Street a	nd Number	or Rural Roy	ita Numbar	City or Town,	State 7in	
<u></u>	Ma	d 2 T te		Teresa Settles/daugh	ter					timore		21225	State, Zip	C006)
	Baltimore,	of of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 1 ☐ Donation 5 ☐ Other (Specify)	m State	p. Place of Dispo cemetery, crer	sition (Name	e of		Date		Oc. Location -	City or To	wn, State
	Balt	permit. Pag Department Important: I any injury o		21. Signal of Funeral Sarvie Licensee Ronald S. Wade,	Direct	or St	Name and tate A altimo	nato	my Bo	ard 65	55 W.	Baltim	ore S	treet
12 29 a	8760,	Physician /Medical Examiner phonial-transit ph	icai Examiner	Sequentially list conditions, any least ling terms of law cause. Enter Underlying Cause (Disease or Injury that initiated events	to (or as a cons	equence of):		of dying	, such as c	ardiac or ress	piratory arre	st.		Approximate Interval Between Onset and Death
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8		uires tha signed Id be de	by	Part II. Other significant conditions contributing to	death but not r	esulting in the u	nderlying ca	use give	n in Part I.	2				e cause of death?
K	Vital Records,	The law requii sate has been s page 2 should	Completed								4a. Was an autopsy perform	ed?	Vere autoportion to com	sy findings available apletion of cause of
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	Division of \	ding Physician: h. After this certific funeral director,	ion: To	27. Manner of Death 1 Natural 5 Pending (M	Inpatient 2 te of Injury onth, Day Year)	ER/Outpatien 28b. Time of Injury	28	c. Injury Work	at ?	28d. C		ce 6 Other)
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		To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by		29a. Certifier 1 X Certifying Physician: To	he best of my k	nowledge death	n occurred at	t the time	e, date and	place and di	ie to the car	see/s) and ma	nner as sta	ated.
		To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examiner: On the	basis of exami anner stated.	nation and/or inv	vestigation, i	n my opi	nion, death	occurred at	the time, dat	e and place, a	ind due to	the cause(s)
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		8		30. Name and address of person who completed co	د مه د	Na	Print)			Hus				
		Sta Registr	_	31. Date filed (Month, Day, Year) MAR 3 1 2004	Registrar's Sig	nature	R)		.,,,,	, ,	, , , , ,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Items 28a-f per Dr., GS29, 03/31/74(h) Reg. No. Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician PM DOWEL UUIAP 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Montino Medical 5,5km Baltimere, no N/A If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 36 Days Months Hours Director Feb. 4, 1968 220-78-6581 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Itama 23a or 28a-f show the Medical Exemple at must be notified at Maryland Anne Arundel Glen Burnie 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6343 Harris Heights Ave. 21061 U. S. A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 25 No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturet, or fits ary or other traumatic event, the Maclicia Exactina 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo White Specify: Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bar Maid Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pierre Monteil Beulah Schrader ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21261 William Carter Bowen, Sr. husband 6343 Harris Heights Ave. Glen Burnie, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Crestlawn Memorial Gardens 03-08-04 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 21. Signature of Funeral Service Licensee epens 2 2719 Hammonds Ferry Rd. Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 15 chemia and subsequent brain swelling **Physician** /Medical Due to (or as a consequence of): Stroke Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Onknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No SMOKIN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has blirector, page 2 s autopsy performed3 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: 1 Inpatient 2 EN/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending death. s after death.
I Director: A 12:00 investigation 1 Tyes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1342 ilovois ilegat he clea within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD-D6459159

State Registrar

DHMH 17 Rev 1/2001

MAR 3 1 2004

John W Cole, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Umms Dept of Neuroium

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sports

22 S Greene St Baltimore, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 5007 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Month **Physician** March 26, Nita L. Cowell 4:00AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 3/15/1913 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2☐F 91 413-09-1294 Yrs. Virginia Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Prince George's Oxon Hill 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5630 Fargo Ave. 20745 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Wes 2 □ No WWII If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry iring most of working Elementary/Secondary (0-12) College (1-4or 5+) Accounting National Geographic permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie. Important: If item 27 is marked other ti any injury or other traumatic event, Ith 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick W. Zimmerman Bertha E. Nalls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Jones/Sister 38 Diggs Drive Hampton, VA. 23666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Washial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/30/04 Suitland, MD. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Geo. P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine physician and s the burial-transit resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 2 No 1 Yes or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled o the Hospital in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)
MAR 3 1 2004

Louis V.

DHMH 17 Rev 1/2001

Kanfman, MD 12070 Old Line Centre Suite 207 Waldorf, MD. 20602

cortoleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

_			1 – For State Registrar	State of M	aryland		artmen <i>tificat</i>				R	eg. No.	20	04	098	45
	Physici /Medio		1. Decedent's Name (First, Middle, Las Shirley Virginic	a Conlin							2. Date of Dea Month March	Day	,20		3. Time of Dea	
	Examir Funeral	ier	4a. Facility Name (If not institution, give 342 OLd Conowing 5. Social Security Number 6. S	go Road	je (In yrs. la	st birthday)	C If Under	ONOW 1 Year	If Under 2	24 Hrs.	8. Date of Birth		Ceci	L Birthol	ace (State or Fo	reign
	Director		093-18-1049 Usual Residence of Decedent 10a. State 10b. County	□M 2 X 1F	79	Yrs.	Months	Days	Hours	Min.	Month, Day Feb. 26	, Year	925		York	
	the Maryla 286-f shov	ector	Maryland Cec	il		onowi		Code				On Citi:	zen of Wh		ld. Inside City Lin 1 ☐ Yes 2 🛣	
	ath with	Funeral Director	342 Old Conowing					2	1918			U	ISA			
036	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or tems 23e or 28e-1 show ant, the Medical Exam or must be Indified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give Year or Dates:			Vas Deced fYes, spec I□Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		I4. Race - Black, Specify:	White, e		
21215-0036	I within 72 ho iene. r then "netui Itie Medicul	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Deced (Give life. L	kind of wor OO NOT us	rk done d	urina most	of working	g		nd of Busi		ustry	
yland 2	ould be filed Mental Hyg arked other etic event,	To Be C	17. Father's Name (First, Middle, Last) William Smallman	1							(First, Middle, i					
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or ftems 23e or 28e-f show any riqury or other treumetic event, the Medical Examin at must be calling at ance.		19a. Informant's Name/Relationship (3 Sharon Malbone/1 20a. Method of Disposition	Daughter	20b. Pla	342	Old C	onow	ingo	Rd.,	Route Number Conowite	ngo,	MD	2191	8	
Baltimo	permit. Page Department of Importent: If any injury or once.		1 ☐ Burial 2 ② Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Licents)	()	R. 7	T. Foa	rd Fu	inero d Addres	L Hor	/					m, State Marylano	ł
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.O. Box 6	ires that the death certific signed by the attending pl d be detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel o	death 3□	Ectopic pro Other (spe					2	3d. Date of Month		y Day Year	
S, T	w requires that I been signed by should be deta	۾	Part II. Other significant conditions c	ontributing to death b	ut not result	ting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to				cause of death	
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\ite	Physicien: this certificaral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatie	ent 2□E	R/Outpatien	3 🗆 DO	A Othe			Check only on		□Other	(Specify)	Ť.	
Division of	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ry 2	28b. Time of Injury		8c. Injury Work		28	d. Describe ho			(Opcomy)		
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	To the Hospitel or within 24 hours after To the Funerel Director Completely filled in the formulation of the	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exan	ysician: To the best niner: On the basis o and manner st	f examination at the state of t	on and/or inv	estigation,	in my op	inion, deat	h occurred	d at the time, da	ate and	place, and	d due to	he cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	MD			29c	License	number	L	2	9d. Date	signed (Month, D	ay, Year)	
	V		30. Name and address of person who	completed cause of of Stafforts 32. Registr	leath (Item :	23a) (Type,	Print)	0.5%	eaks.	three	ice E	ikto.	2. M	D , '	004	
	Sta Registi		31. Date filed (Month, Day, Year) MAD 3 1 2004	32. Registr	ar's Signatu	Spo	Ms	-,u/	- ve	W ~ 7f			1			

		1	For State Registrar	State of	Marylan	d / Depa <i>Cei</i>	artment of F	lealth and M Death	lental Hyg	giene Reg. No. 2	04	09846
	Physiciar /Medica	1		ONI		NAUGH			2. Date of Dea Month MARCH	25 ^{Day} 2004		3. Time of Death 4:30 P M
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	Funeral Director		5. Social Security Number 6 212-42-4751 Usual Residence of Decedent	Sex 7	. Age (In yrs. I	Yrs.	Months Days		8. Date of Birt (Month, Da) Feb.06	y, Year)	9. Birtop Cour Mary	place (State or Foreign ntry) r land
	Maryland a-f ehow	101	Md. Harford	County		, Town or Lo Havre	cation De Grace				1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28a in the contract of 25a or 28	al Director	10e. Street and Number 203 Fender Cour	t			10f. Zip Code 210	78		10g. Citizen of U.S.A		ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 or 28a-f show any injury or other traumatic event, the Medical Exprision to the modified of Any Expression of Any Expression Dispersed.	חין ער	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 ☐ Yes 2 If Yes, Give Year or Dat	es? 2 □XNo		Was Decedent of F f Yes, specify Cub 1 ☐ Yes 2 ☐ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ce - Americ ick, White, fy: wh	
altimore Maryland 21215-0036	within 72 ho ene. than natu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4	4or 5+)		dent's Usual Occup kind of work done DO NOT use retired ewife and	pation during most of work d) Mother	ing	16b. Kind of E		dustry
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7	alth and M		19a. Informant's Name/Relationship Richard P. Cavar		(Husl	19b. Mailir land)	ng Address (Street 203 Fende	and Number or Run	al Route Numbe Havre I	or, City or Town De Grac	. State, Zip e , Md	. 21078
a vo	Pages 1 and the part: If item	200	20a. Method of Disposition 1 ∰ Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Spe	cify)	tate Mea	emetery, cren adowri	sition (Name of natory or other place dge Memon	rial Pk.03	3/29/04	20c. Location Elkrid		
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	13	-	30. Name and address of person wh		of death (Item	23a) (Type,	Print)	2609		13/18	7	
	\		Kammeden Mi	thani Ms	11061	Revolu	fion St.	Houre A	e Grae	e.MDS	107	3
	State Registrar		30. Name and address of person which will make the state of the state	32. Reg	gistrar's Signal	A A	als					

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	Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) VERNON 4a. Fecility Name (If not institution, give st STACNES HEALT		L	4b. City, Tow	vn, or Location of Dea	2. Date of Dea Month NARCH	Day Year 2004	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex		(In yrs. last birthday) 77 Yrs.	If Under 1 Y		8. Date of Birtl	NA 9. Bir 926	thplace (State or Foreign ountry) MD
	h the Marylander 28e-f show	Director	10a. State 10b. County MD NA 10e. Street and Number		10c. City, Town or Lo	BALTIM 10f. Zip Co			10g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No puntry?
VO V	be filed within 72 hours after death with the Maryland ntal Hygiene. do other than "natural", or Items 23s or 28s-f show event, the Madical Examiner must be notified at	by Funeral D	416 N. DENISON STRI 11. Marital Status	2. Was Decedent Ex Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	ver in U.S. 13. 13. 15 1945 - 1946	Was Decedent If Yes, specify	21229 of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		
VERNC 21215-0036	within 72 hour iene. rthan *natural' the Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	dent's Usual O kind of work d DO NOT use n	one during most of wo etired)	rking	16b. Kind of Business BALTIMORE C. OF EDUCA	ITY DEPT.
LL Vland	2 should be filed and Mental Hygie is marked other sumatic event, it	To Be C	17. Father's Name (First, Middle, Last) WILLIAM R. CAN 19a. Informant's Name/Relationship (Type)				18. Mother's Na	ET DORSEY	Maiden Surname) r, City or Town, State,	
CAMPBE Baltimore Mai	t Pages 1 and 2 nment of Health a nant: if Item 27 is nury or other tre		MARIE M. CAMPBELL (WIFE 20a. Method of Disposition 1 [X] Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	emoval from State	20b. Place of Dispo cemetery, created GARRISON FO	natory or other REST VET	of r place) C. CEM 4/5	-	21229 20c. Location - City or OWINGS MILL:	
	Physician		23a. Parl I. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused to e cause on each line	the death. Do not ent	638 N. ser the mode of	GILMOR STRE	ET BALTIM c or respiratory an		Approximate Interval Between Onset and Death
750		Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a NON -HC Due to (or as a	consequence of):	Lym	PHOMA			WOWINS
D O Roy 687	eath cer attendir for use	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome o 1 Live birth 2 4 Pregnant at t 9 Unknown	Fetal death 3	Ectopic pregn Other (specif			23d. Date of de Month	livery Day Year
	w requires that the been signed by should be detact	by	Part II. Other significant conditions con	tributing to death but	_	nderlying caus	e given in Part I.		obacco use contribute t 'es 2 ☐ No 3 ☐ P	o the cause of death? robably 4 Unknown
Poor is	ysician: The law re is certificate has be director, page 2 sh	Completed	HYPERTENSION				00.8142	1 🔀 Yes	rmed? death? 2 No 1 Yes	utopsy findings available completion of cause of
Oivision of Wital Becords	nding Physicial th. :: After this certif	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	ospital: 1 Na Inpatien 28a. Date of Injury (Month, Day	t 2 ER/Outpatier / Yeer) 28b. Time o Injury		0.4		ne) dence 6 ⊡Other (Spe dow injury occurred	ecify)
A isin	tel or Atter rs after dea al Director led in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, of	ffice	28f. Location (S City or Ton	Street and Number or R rn, State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Medicai			examination and/or in	vestigation, in		urred at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mon	e to the cause(s)
	F 3 F 8	a distribution	Numpuned.		ath (Item 23a) (Type,		P17600		03/29/1	
	Sta Regist		30. Name and address of person who completely and address of person who completely and address of person who completely and address of person who completely and address of person who completely addr	A ST AG	NES HEA	HITH CF	TRE, 9800	TION AVE	BACINO	KE, MW-2122

Physic /Medi		1. Decedent's Name (First, Middle,	CAMMO	N					2. Date of Di Month	eath Da	20	ear 04	3. Time of 2:00	
Exami		4a. Facility Name (If not institution, 4234 Falls Road	give street and number,)		4b. City, Town	n, or Location	on of Death		4c.	. County of I	Death		
Funeral Director		212-22-6003	6. Sex 7. Ag 1 ☐ M 2 X F	ge (In yrs. last 95	Yrs.	If Under 1 Ye Months Day		er 24 Hrs. s Min.	8. Date of Bi (Month, D. Jan. 21,	rth ay, Year) 1909	9.	Birthplac Country	ce (State o	r Fore
natural', or items 23a or 28e-f show digal Examiner must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Balti	imore	10c. City, To	own or Loc							10d	I. Inside Cit	-
or 28e-	Director	10e. Street and Number		Dai	CHIDLE	10f. Zip Code	9			10g. Cit	tizen of Wha	it Country	/?	
stal Hygiene ud other than "natural", or items 23a or 28e-f show event, the Medical Examiner must be notified at	by Funerai	4234 Falls Road 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ad 1 \(\triangle \triangle \triangle \) If Yes, Give Year or Dates:	?	If	21211 Vas Decedent of Yes, specify C	uban, Mexid	can, Puerto	pecify Yes or No Rican, etc.)		USA 14. Race - A Black, N	American White, etc	c	
400	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)			(Give k	ent's Usual Occ kind of work doi O NOT use ret	ne durina m	ost of work	King	16b. K	ind of Busin	ess/Indus	stry	
nd Mental Hygiene. marked other than matic event, the M	To Be Con	8th Grade 17. Father's Name (First, Middle, La Emanuel Brown Sr	ast)		Homer	Maker	18. Mo		e (First, Middle Brown		Mn Hom Sumame)	e		
ē <u>≘</u>	F	19a. Informant's Name/Relationshi	_	1	1001				ral Route Numb	er, City o	or Town, Sta	te, Zip Co	ode)	
nent of Health int: If item 27 iry or other tr		Marty Fisher/ Nep 20a. Method of Disposition 1 Burial 2 Commation 3 4 Donation 5 Other (Spe		ceme	e of Disposi etery, crema	Falls R. ation (Name of atory or other p	olace)		re, MD 2 Date		sville		n, State	
Department of important: If i any injury or once.		21. Signature of Funeral Service Li Steven H.	icensee		Ĉ		ress of Fac	eral A	lternativ				asture	s
uninian	burial-transit ueigen ueigen ueigen ueigen und und und und und und und und und un	shock, or heart failure. List or Immediate Cause (Final	nly one cause on each l	d the death. Dine.		r the mode of d	lying, such	as cardiac	or respiratory a	rrest,	0.45	In	pproximate iterval Betw inset and D	ve er
sician and sician and sician and sician and sicial-transit	Examin	shock, or heart failure. List or	a. Due to (or as b. Due to (or as c.	d the death. Dine.	ce of):	r the mode of d		as cardiac	or respiratory a	ey I	Di SE K	In	terval Betv	veer
Altending physician and common and common and common as the burial-transit	icai Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Due to (or as b. Due to (or as c.	ine. BABI a consequence a consequence of pregnancy 2 Fetal dec	ce of):	r the mode of d	ying, such	as cardiac	or respiratory a	Ry 1	23d. Date of Month	In O	iterval Betwinset and C	veer
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this certificate has been signed by the attending physician and inperior, page 2 should be detached for use as the burial-transit in pro-	o Be Completed by Physician/Medical Examin	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	a. Due to (or as b. Due to (or as d. Due	ine. BAB Ba is a consequence is a cons	ce of): ce of): ce of): ce of): dath 3 E	Ectopic pregnar Other (specify) derlying cause 1 3 DOA 28c. In WM 1 et, factory, office	ying, such and a such a	t I. Ce of Death Nursing Ho	23e. Did to 1 24a. Was autopento 1 Yes to Check only of City or Total and due to the	cobacco u Yes 2 an psy 2 XNo one) dence (how injury wn, State)	Month use contribut No 3 [24b. Were prior death 1 [6] Other (5) y occurred d Number of	delivery Da te to the co Probable a autopsy to comple Yes Specify)	ay Y cause of de ly 4 □U r findings a letion of ca	ear ear nkne vail

JULIA DAVIS 04-DAP

20:	14			ype or Print in				•		egible.	
			1 - For Unpend Item #23a Registrar	-8;9tc.11,27°(xer	The 6830 Ce	युपायल्यः rtificate of	Death	Mentai myt	leg. No.2	004	1981.0
	Dhysiai	on	1. Decedent's Name (First, Middle, Last)			-		2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medi		Julia		Davis			MARCH 2			8:28 a M
	Examir	ner	4a. Facility Name (If not institution, give s 501 MCELDERRY STREI				r Location of Deat	th	4c. Co	unty of Death	
			5. Social Security Number 6. Sex		s. last birthday)	BALTIMOF If Under 1 Year	RE CITY If Under 24 Hrs	8 Date of Birth		NA G Bisto	place (State or Foreign
	Funeral Director			M 2X2F 45	Yrs.	Months Days	Hours Min.		Year)	Cou	ntry)
	land w ====================================		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	Mary s-f sh	to	Md. NA		Baltim	ore					1 X Yes 2 □ No
	or 28s	Director	10e. Street and Number			10f. Zip Code			0g. Citizer	of What Cou	ntry?
	72 hours after death with the Maryland natural', or Items 23a or 28a-f show pleat Examinat be notified at	a D	501 McElderry Str	reet		21	202		US.	A	
	tems from	Funeral		12. Was Decedent Ever in the Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14.	Race - Ameri Black, White,	
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑No If Yes, Give		1 ☐ Yes 2 🙀 No	Specify:		Sp	ecify:	l = =le
8	tural	ed I	15. Decedent's Educ	Year or Dates:	16a Dece	dent's Usual Occup	ation		16h Kind	of Business/In	lack
5	n "ne	plet	(Specify only highest grade Etementary/Secondary (0-12)	completed)	(Give	kind of work done of DO NOT use retired	during most of wo	rking	TOD. KING	or businessyn	idustry
21215-0036	e filed within at Hygiene. other than "vent, the Me.	Completed	11th grade	College (1-4or 5+)	Dome	estic			Othe	r Peop	le Homes
g	be filed ttal Hygi ed other event, II	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle,	Maiden Su	mame)	
Maryland	should bent marked umartic e	2	Roosevelt	Davi			Jane	Mae		Wooda	
Jar	ages 1 and 2 should be filed within 72 hours after death with the Marylan nt of Heath and Mental Hygiene. If item 27 is marked other than "naturat", or items 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Ty)		1	ng Address (Street					
	s 1 and 2 if Health a item 27 is other trau		James Davis Bro	other		Langfor	a Ra., B	-		21207	
altimore,	permit. Pages Department of H Important: If ite any injury or of		1 ⊋Burial 2 ☐ Cremation 3 ☐ R	emoval from State	cemetery, cren	natory or other place				ion - City or To	
	artme artme ortant injury		 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 	3 17	The second second	nel Cem. . Name and Addres		1-04		alk, Mo	
Ba	Depois any source		1	1/1/2-5		arch F.H		вал 1101 Е.		re, Md.	
г	-		23a. Part1. Enter the disease, or complic	cations that caused the dea	1					ui Ave.	Approximate
	Pnysician		shock, or heart failure. List only on tmmediate Cause (Final	Probable Arryt	-bmia Duo	То					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse		10					
	Examiner		Conventially list conditions	Hypertensive A	Atheroscl	erotic Card	liovascular	Disease			
100	P =	iner	Sequentially list conditions. (if airy, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of).						
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	·							
760,	be ex cian a	alE	and the second s	Due to (or as a consec	quence ot);						
	icate be executed physician and s the burial-transit		d								
Box 68	eath certificate attending phy: I for use as the	Physician/Medic	IF FEMALE:	3c. If yes, outcome of pregn	nancv				224	Date of delive	
	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \)	1 Live birth 2 Feta 4 Pregnant at time of a	al death 3 [Ectopic pregnancy Other (specify)			230.	Month	Day Year
P. O.	that the de ed by the detached	hys	9 A Unknown	9□ Unknown							
	The law requires that the death certificate tite has been signed by the attending physionage 2 should be detached for use as the	by P	Part II. Other significant conditions con	tributing to death but not re-	sulting in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use	contribute to th	ne cause of death?
ä	w require been sig should b	ed	Seizure Disorder					1 □ Y€	s 2 🗆 N	o 3□Prob	ably 4 🕅 nknown
ပ္ထ	law re as be 2 sho	Completed						24a. Was a	2	4b. Were auto	psy findings available
ř		Com						perform	red?	death?	mpletion of cause of 2□ No
<u> </u>	Attending Physician: The r death. ector: After this certificate hiby the funeral director, page	Be (25. Was case referred to medical examiner?				26. Place of Dea	th Check only on	-		
Division of Vital Records,	Physi this c	ဥ	AAI 63 Z	ospital: 1 Inpatient 2			4 U Nursing H				wat scene
ב	ding Ph h. After th funeral	lon	27. Manner of Death 1XXNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe ho	w injury oc	curred	
<u>s</u>	Attencer death	ertification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome farm stre		Yes 2 □ No	28f. Location (St.	not and Ni	imbor or Pum	I Pouto Number
≧	after Dire	ertii	4 Homicide determined	building, etc. (Speci	fy)	set, ractory, office		City or Town		inder or hura	i noute ivaniber,
	spital nours a nera! [O	29a. Certifier 1 Certifying Phys	ician: To the best of my kno	owledge, death	occurred at the tim	e, date and place	, and due to the ca	use(s) and	I manner as st	ated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	ation and/or inv	estigation, in my or	pinion, death occu	rred at the time, da	te and pla	ce, and due to	the cause(s)
	To the le within 2. To the I complete	ž	29b. Signature and title of certifier			29c. License				gned (Month.	*
7			> Gues C			OCI	ME	MA	ARCH 2	22,2004	<u>l</u>
			30. Name and address of person who cor								
			31. Date filed (Month, Day, Year)	JB10, FD 32. Registrar's Signa	aturo	11 Penn	Street, 1	Baltimore	, Mar	yland	21201
	Sta Registr		MAR 3 1 2004	- 12.		and i					
			mair o T 7004	1 1 1 1 4 2 4 A B & A	2 A. C.	1364 F					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2.0.0.1

		AMEND TTEM #21&22 PER F.		h Certi	ficate of	Death		g. No.	3. Time of Death
п	Physician	Cecil DeShazo	,				Month March 2	Day Vear	11:25 AM
	/Medical Examiner	4a Facility Neme (If not institution, give				4b. City, Town, or L	ocation of Deeth	4c. County of Deet	h
	•	Genesis Lochra		Land Brinds at 1	If Under 1 Year	Baltimon		Baltimor	
	Funeral Director	5. Social Security Number 218-62-3162	x 7. Age (<i>In yrs</i> . 49	N. C. C. C. C.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Dec 3,		hplace (State or Foreign untry) ryland
	Meryland -f show	10a State 10b County	/ 7\	y, Town or Loca Baltimor					10d. Inside City Limits 1 Yes 2 □ No
	ritems 23s or 28s-f sining must be notified inner must be notified Funeral Director	10e. Street end Number 529 Richwood Aver	nue		10f. Zip Code	212	10	g. Citizen of What Co USA	
020	by Br.	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:			lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, White	rican Indian,
2-0	72 ho	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Deceder (Give kir.	nt's Usual Occup ad of work done	oation during most of world)	king	6b. Kind of Business/I	Industry
Maryland 21215-0020	led within 72 ho lygiene. ner than "naturi nt, the Medical I Completed	Elementery/Secondary (0-12) unk un	College (1-4or 5+)		aborer			bethlehem	steel
and	ntal Hygie ed other event, it	17. Father's Neme (First, Middle, Last) Byrd DeSha	20				e (First, Middle, Mi INE MCC)		unk
ary	marke marke marke	19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (Street			City or Town, State, 2	(ip Code) unk
	and 2 selth e n 27 is	Martha DeShazo/s		1		RK LAKE			E,MD.21217
Baltimore,	nit. Pages 1 entment of H ortant: If iter injury or ott	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒ Other (Specify)	Removal from State VC		tory or other pla MEMOR I	AL PK.	APR.6,2		IMORE, MD.
Balt	permit. Depertimonta	21. Signature of Funeral Service Licens ROTIC C. BERNADINE V. SCRUCE		r Sta Bal	lame and Addre	ess of Facility Omy Board SCRUGGS, FUN	ICKAL DAME.	Baltimore PRESTON ST F	Street SALTO,MD, 21213
		23e. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the deat ne cause on eech line.					st,	Approximate Interval Between Onset and Death
1	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· Metasteile	e Colo	n Can	en		1	manle
	sit sit		Due to (c	or as a conseque	ince or):				*
ó,	rificate be executed ag physician and es the burial-transit	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	or as a conseque	nce of):				
x 68760,	entificete be ling physicia e es the bu	resulting in death) Last	Due to (a	r as e conseque	nce of):				
Вох	attend for us							İ	
P.O.	requires thet the death certi been signed by the attending should be deteched for use a ched by Physician/M	Part II. Other significent conditione cor	ntributing to death but not res	ulting in the unde	erlying cause giv	ven in Part I.			to the cause of death? obably Unknown
Records,	¥ 20 0						24a. Wes an	ed? a	Were autopsy findings available prior to completion of cause of death?
=	The law ate hes the page 2 s						1 □ Yes	2 X No 1	☐ Yes 2DXÑo
Vital	Iclan: certific rector,	25. Was case referred to medical examiner?	Hospital:		3 DOA Oth	nor:	th (Check only one		
of	Attending Physician: r death. sector: After this certific by the funeral director, iffication: To Be (27. Manner of Deeth	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of	3□ DOA 28c. Injui	4 ILL INUISING TO	ome 5 ∐ Residen 28d. Describe hov	ce 6 Other (Spec v injury occurred	oify)
ioi	anding sath. or: Afte he fun	1 Neturel 5 Pending 2 Accident investigation	(Month, Day 19al)	Injury		Yes 2□No			
Division of	s effection of in Cert	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street y)	t, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	he Hospit in 24 hour he Funera pletely fills edical (elclan: To the best of my kno ner: On the basis of examina end manner steted.						
_	Vithin 2 Vit	29b. Signature and title of certifier	end manner steted.		29c. Licens	se number	29	d. Date signed (Month	n, Day, Year)
	~	Ynartra Agum	undo mo		05451	18	3	126/04	
	3	30. Name end eddress of person who co	empleted cause of death (Item	n 23e) (Type, Pri		MN 21239	,		
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	<u> </u>	11114/477			
	Danielana"	1000 0 4 0008	Fr. a and	19 1	20 W. /.				

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State of Maryland / Department of Health and Mental Hygiens 2004	00051
Certificate of Death	ICOEU

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	Physic	ian	1. Decedent's Name (First, Middle, Last)					2. Date of De		Year	3. Time of Death
	/Med	ical	Ma. Facility Name (If not institution, give s	ark A. Evans		41. Ch. T.		March	29. 2004		0548 P. M
	Exam	ner	Johns Hopkins Hos	spital			r Location of Deat altimore	n	4c. County	of Death	
	Funera Director	_	211 00 0007	7. Age (In yrs. 48	last birthday) Yrs.	If Under 1 Year Months Days	Il Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Oct 24	v. Year)	9. Birthpi Coun North	ace (State or Foreign try) Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10	Od. Inside City Limits
	Many a-feh	ţċ	Maryland Anne Aru	ındel G	len Bur	nie					1 ☐ Yes 2 X ☐ No
	vith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Coun	try?
	eath v	era	525 Oakwood Stati	on Road 2. Was Decedent Ever in U.	6 12 4	2106			U.S.		
900	If y fall (Z Z D-UO30 should be filed within 72 hours after death with the Maryland ad Mental Hygiene. marked other than "natural", or items 23e or 28e-f show imatic event, the Medical Experiment be notified at	by Funeral	1 1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - America k, White, e : Whit	etc.
Poltimoro Manufacto 0404E 0006	thin 72 ho	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life. D	ent's Usual Occup kind of work done o	ation during most of wor	king	16b. Kind of Bu	siness/ind	ustry
Č	be filed winter the dother the	Co	(unknown) 17. Father's Name (First, Middle, Last)		Roof	er			Constr		on
Ì	yidilik buld be f Mental H arked ot atic ever	o Be	James T.	Evans					Maiden Sumam M. Humph	*	
Š	2 should and Men is marke	ို	19a. Informant's Name/Relationship (Typ		19b. Mailing	Address (Street a	and Number or Ru		-	_	Code)
2	ie, Mal yle s 1 and 2 should f Health and Mer item 27 is marke other traumatic		James T. Evans /		303 E	dgemere I			is, Mary		
ì	permit. Pages 1 and 2 sh permit. Pages 1 and 2 sh Department of Health and Important: If tiem 27 is n eny injury or other traum		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval Irom State	emetery, crem	ition (Name of atory or other plac rematory		Date /2004	20c. Location - (Baltimor		
200	permit. Departrimports eny inju		21. Signature of Funeral Service License	•	1 22.	Name and Addres	is of Facility Go	nce Fun	eral Ser	vice.	P.A.
1			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death			ie Highwa g. such as cardiac	-		Mary	land 21225 Approximate
•	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	21	it co.	mplicati	(nterval Between Onset and Death
	secuted and I-transit	Examiner	Sequentially list conditions, if any, leading to ammediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a consequence to (or a consequence to (or as a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a consequence to (or a							
68760	icate be executed physician and s the burial-transit	edical E	d.	Due to (or as a consequ	lerice (ii):						
P.O. Box	death cert e attendin d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 E	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery	y ay Year
rds B	requires tha been signed I	by	Part II. Other significant conditions conti	ributing to death but not resu	lting in the und	lerlying cause give	n in Part I.		bacco use contrib		cause of death?
Division of Vital Records	The law ate has b page 2 sl	Completed						24a. Was a autops perfori 1 🔀 Yes	ned? de	ere autops or to comp ath? 2Yes 2	y findings available pletion of cause of
ž	Physician: this certificanal director,	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	spital: 1 🔀 Inpatient 2 🗆 E	70.	all pos Othe	26. Place of Deat				
٥	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury Work	4 Nursing Ho		ence 6 Other		
Sign	Attendir death. ctor: Af y the fu	catlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Scuicide 6 ☐ Could not be	Mark 24, 2004	10:30 1	>M 1 □ Y	es 212 No	Subject 1	hanged s	ef	
Divi	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification;	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	bookena	cell		300 €. W	ladison,	BULTI	are more
	e Hosi 24 ho e Fune etely fi	Medical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☑ Medical Examina	cian: To the best of my know r: On the basis of examination and manner stated.	rledge, death o on and/or inve	occurred at the time stigation, in my opi	e, date and place, nion, death occurr	and due to the ca	ause(s) and manr ate and place, an	ner as state d due to th	ed. e cause(s)
	To th within To the compl	Me	29b. Signature and title of certifier Josha R. M.	zerbero M)	29c. License	number ME	2: N	9d. Date signed (March 30	Month, Da	y, Year) 4
	3	1	30. Name and address of person who com	pleted cause of eath (Item							
			Tasha Z Greenber				n Street	, Baltin	nore, Ma	rylan	d 21201

State Registrar

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Eunice Delphinia Fullam March 5:00 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 457 Telegraph Road Cecil 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 19, 1 Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F Director 090-22-5046 75 Yrs. New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Cecil Risina Sun 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 457 Telegraph Road 21911 USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" White or than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Ith and Mental Hygiene.
27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 10 Factory Worker Manufacturer 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth any injury or other traumatic event ang. 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Morini ပ Zinnia Natale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Pearsall/Daughter 457 Telegraph Road, Rising Sun, MD 21911 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) R.T.Foard Funeral Home, PA 3-29-04 Rising Sun, MD 21. Signature of Funeral Service Licenses R. P. are address of Furieral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 wharg 23a. Part 1 Enter the disease, or complication hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one calls on each line. Approximate Interval Between Onset and Death Immediat Cause (Final disease or condition resulting in death) **Physician** Premuces /Medical Due to (or as a consequence of): Examiner CUPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No : After this certification, funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification; To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred s after dec. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide within 24 hours a

To the Funerel C

completely tilled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dui seen Her MD DO4623 3/25/64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHIH HUL, MD man St, Elkhon Md 2>3 West 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygien [] []

09853 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2004 10:30 p.m JANET F. FLEMING March 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Allegany Moran Manor Nursing Home Westernport Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🛱 F Yrs. 233-34-7327 Nov. 3,1922 West Virginia Director 81 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours effer death with the Marylend Depertment of Heelih and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examination motified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director WV Mineral Keyser 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 500 Carskadon Lane, Apt. 501 26726 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Yes Give Specify: þ If Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk 8 Gift Shop 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alice Jenkins Ervin Hardy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dottie Rawlings/Daughter Rt. 1, Box 202-B Burlington, WV 26710 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20a. Method of Disposition 20c. Location - City or Town, Slate 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March 27 2004 4 ☐ Donation 5 ☐ Other (Specify) Thrush Cemetery Antioch, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Smith Funeral Home Buant. 85 S. Main Street Keyser, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Dealh **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Advenicarcim A Examiner Due to (or as a consequence of) Examiner ettending physician end for use es the buriel-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by the page 2 should be deteched 1 Yes 2 No 3 Probably 4 Ûnknown Olounic obstruct: w Prosenzo ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate has TLLYES 2X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🕅 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3/26/2004 121244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jesus Tan, M.D. Frostburg Plaza Frostburg, MD 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death Day 1 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death GRAHAM **Physician** ZEP 2.50.M March /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randalistown **Baltimore** Northwest Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 1, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Georgia **Funeral** 1 M 280 F 219-07-1261 85 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits ir than "natural", or itame 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Baltimore Maryland N/A Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 2105 Bradish Ave. 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene important: if item 27 is marked other than "na any injury or other traumatic event, Itta Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Home Home Maker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Calvin Black Maude Black 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2105 Bradish Ave. Baltimore, Maryland 21216 Anna Black 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 03/31/04 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCUAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner MITTEROSCIEROSIS YOARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical t)e 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ELECTROUPTE DISTIRBANCE, REMAL INSUFFICE TO 1 Yes 2 No 3 Probably 4 Minknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 2 2 ER/Outpatient 3 DOA After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Days Year) Many 26 2004 29b. Signature and title of certifier m 30 Mame and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HOSPITAL CENTER I RANGARA TAN OXAMASWAMY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 3 1 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a, PtI, PtII per Dr., G829, 03/31/Oydhb
Amend Items 23a, PtI, PtII per Dr., G829, 03/31/Oydhb
Reg. No. 1 - For A State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** Year MARY MAMMERBACHER 02:40 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NUSING 9. Rehab 8. Date of Birth (Month, Day, Year) June 14, 1959 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1 □ M 2 💢 F 213-70-3697 44 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits 28a-f ehov MD Baltimore 1 √ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or itams 23a or ury or other treumatic event, the Medical Examination was be 9 N. Clinton Street 21212 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ò none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian John Hundertmark Lillian Everhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline Cook/sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Road Baltimore, MD 21220

Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in state 21. Signature of Eureral Service Licenses (Onald Swaa permit. Departn 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 ranvi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Renal Failure Immediate Cause (Final disease or condition Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Acute Liver Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Po in the past 12 months? Day Year 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown record page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus, Hypertension has autopsy performed? certificate 1 ☐ Yes 2 🖼 No 1 Yes 2 🔀 No funeral director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After t Certification: 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dirac 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) MAR 3 1 2004

Andrew Mrowiec

29b. Signature and title of certifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

iGAberdeen Plaza. Aberdeen MD

247804

29d. Date signed (Month, Day, Year) 03/05/2004

Maryland

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Records,

Division of Vital

To the Hospitel or Attending Physician:

			For State Registrar	tate of Mai	ryland / Depa <i>Cei</i>	artment <i>tificate</i>				Re	g. No.	04	09856
	*Physici	an	Decedent's Name (First, Middle, Last)							2. Date of Deat	PYC	Year	3. Time of Death
0	/Medic	al	JAMES E. HANDY 4a. Facility Name (If not institution, give street)			4b. City, T	own or l	ocation of		laken	4c Count	y of Death	1707 "
	Examin	er	St Asnes Ho	spital		40. City, 1	2 1	lim	nRO	,	N/		
	Funeral	**	5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1		If Under 2	24 Hrs. 8	B. Date of Birth (Month, Day,		9. Birthp	place (State or Foreign
	Director		216-16-6744	2 🗆 F	80 Yrs.	Months	Days	Hours	141111.	1-16-1	924	MAF	RYLAND
	and		Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation							I Od. Inside City Limits
	Maryli f sho	ğ	MD. N/A		BALTIMO	RE							1X Yes 2 No
	r 28e	Director	10e. Street and Number		-	10f. Zip (Code			1:	0g. Citizen of	What Cour	ntry?
	th with		722 WICKLOW RD.			2	1229				US	SA	
	ems	Funeral	11.110	Was Decedent Ev Armed Forces?	} 1	Was Decede f Yes, specif	nt of His fy Cuban	panic Orig	in? (Spec Puerto Ri	ify Yes or No- ican, etc.)		ce - Americ	
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates:	•	1 ☐ Yes 2	∑ No	Specify:			Speci	h: BLA	ACK
5-0036	72 hours after death with the Maryland Insturet, or Items 23s or 28e-f show disal Examiner must be notified at	ed t	15. Decedent's Educati	on	16a. Deced	lent's Usual	Occupat	tion			16b. Kind of E	Business/In	dustry
215	within 72 ene. then "ne	plet	(Specify only highest grade co	<i>mpleted)</i> College (1-4or 5+)	life. I	kind of work DO NOT use	done du retired)	uring most	of working	7			ŕ
2121	filed will Hygiene other the	Completed	-12-	-0-		INTEN							MANAGEMENT
Pul	be file ital Hy id oth	Be	17. Father's Name (First, Middle, Last)							First, Middle, M	Maiden Suma	me)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other then "neturel", or items 23c or 28e-f show other treumatic event, If a M. Alical Examiter must be notified at	ပို	WALTER J. HANDY 19a. Informant's Name/Relationship (Type,	Print)	19h Mailir	n Address /	Street at			SCOTT Route Number	City or Town	State Zin	(Code)
N N	and 2 s ealth an n 27 Is:		VERNON A. DIXON(N							MORE, M	-		
ē,	of Health item 27 other tre		20a. Method of Disposition		20b. Place of Dispo	sition (Name	e of ner place) 4-	-5 - 20	04	20c. Location	- City or To	own, State
Ë	Pages nent of I ent: If ite ury or o		14 Burial 2 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		GARRISON F	-					WINGS	MILLS	MARYLAND
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 any injury or other tr once.		21. Signature Funeral Service Licensis	ERMON R.						EY FUNE • BALTI			AND 21217
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of	ons that caused the	he death. Do not ent	er the mode	of dying,	, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Pnysician	(0 J	Immediate Cause (Final disease or condition			fare h							Onset and Death VN YNOWN
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):							-	
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
ó	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Еха	resulting in death) Last	Due to (or as a	consequence of):								
8760,	ate be hysici the bu	dical	d										
9	ertific ding pl	/Mec	IF FEMALE:	If yes, outcome of	programmy								
Вох	leath certifica attending ph d for use as the	by Physiclan/Me	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	Fetat death 3	Ectopic pre Other (spe						ate of delive onth	ory Day Year
0	that the death ed by the atte detached for	hysi	1 Yes 2 No 9 Unknown	9□ Unknown			,,						
ر. در	signed b	by P	Part II. Other significant conditions contrib	uting to death but	not resulting in the u	nderlying car	use giver	n in Part I.		23e. Did tob	acco use con	tribute to th	he cause of death?
ord	w require been sig should b	ted							- 1	1 🗆 Ye	s 2 🗆 No	3 Prob	pably 4 Wunknown
Records,	S d S	Completed								24a. Was a autops	24b.	Were auto	psy findings available mpletion of cause of
											Z No	death?	21 No
Vital	Physiclen: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	oital:	ardenia		Othor			Check only on			
o	Phys or this oral dir	1: To	1 Yes 2 No	1 ☐ Inpatient 8a. Date of Injury	28b. Time of		c. Injury	at		e 5 🗌 Reside			у)
ion	ttending I death. ctor: After t the funer	ation	1 Accident 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	М	Work? 1 ☐ Y	? es 2 □ N	10				
Division	er der recto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	8e. Place of Injury building, etc.	y - At home, farm, str (Specify)	eet, factory,	office		28	f. Location (St. City or Town	reet and Num , State)	ber or Rura	al Route Number,
	urs aft					-							
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 ☑ Certifying Physici (Check only one) 2 ☐ Medical Examiner		xamination and/or in	vestigation, i	in my opi	nion, deat		d at the time, da	ate and place,	and due to	the cause(s)
•	To the within 2 To the complet	Σ	29b. Signature and title of certifier	GM			License			2:	od. Date signe	ed (Month,	Day, Year)
	12						1473	17		//	lakch	29	2007
	γ\		JULY 1. 10 10 1 2	100 Caton	Nenve	Bal	time	re,	Maryl	and -	21229		
	Sta Regist		MAR 3 1 2004	See Hegistrar	's Signature	と					_		

4-2152		1 - For Unpend Item#23a,P	State of Mar artII,27,Perl	yland / De E,G830,4 /	epartme 23/04e Prilica	ent of Fate of	lealth a Death	and Me	ental Hy	giene	2004	0005
		Decedent's Name (First, Middle, Last,							2. Date of De	ath		3. Time of Deat
Physici		CATHERINE CLA	RK HIP	KINS					Month MARCH	Da O	-	1210 F
/Medio		4a. Facility Name (If not institution, give			4b. Ci	ity, Town, o	or Location		MARCH	28	2004. County of Deat	
Exami		4006 WAKEFIELD LA	NE		В	OWIE				I	PRINCE G	FODCEC
Funeral	-	5. Social Security Number 6. Sec	7. Age (In yrs. last birthe	day) If Uni	der 1 Year	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da	th Voor		hplace (State or For untry)
Director	Н	215-74-0092]M 2∏F	49 Yr	s. Month	ns Days	Hours		FEB 24			YLAND
ъ.		Usuat Residence of Decedent	12	0 - C'h - T								
aryla	Ļ	10a. State 10b. County		Oc. City, Town	or Location							10d. Inside City Lin 1 X Yes 2 □
M 5 € 88 - 1	Sct	MARYLAND PRINCE G	EORGE'S	BOWIE								
with the	Director	10e. Street and Number	E.		10f.	Zip Code	_			-	tizen of What Co	untry?
1036 burs after deeth with the Maryland ral', or Itame 23a or 28a-f show Examine must be notitied at	Funerai	4006 WAKEFIELD LAN	L 12. Was Decedent Eve	or in II C	12 Mas Da	20715		i=i=2 /C===		U.S	. A . 14. Race - Ame	dana Indian
ltam Itam	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	ei in 0.5.	If Yes, s	pecify Cub	an, Mexicar	n, Puerto R	cify Yes or No lican, etc.)	_	Black, White	
336 Irs af	by	3 Widowed 4 XDivorced	1 ☐ Yes 2√ No If Yes, Give Year or Dates:		1 🗆 Yes	2 ₹ No	Specify:				Specify: W	HITE
15-0036 72 hours after dee "natural; or Itame	ed	15. Decedent's Edu	cation	16a. D	ecedent's U	sual Occup	pation			16b. K	ind of Business/	Industry
215 5 cie	pie	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(6)	Give kind of ife. DO NO1	work done Luse retired	<i>duri</i> ng mos d)	t of workin	g			
212 d with	Completed	12	1		MINIST	RATI	JE ASS	SISTA	VT	НО	SPITALI'	ΓY
other the	Be	17. Father's Name (First, Middle, Last)		0.100			18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
//au	2	FRANKLIN M. CLARK					MARY	7 N. I	HUBBARI)		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or its any injury or other traumatic event, tra Medical Essoins once.	1 2	19a. Informant's Name/Relationship (Ty									or Town, State, 2	
y Mand Salth n 27		KATIE S. BEAN/DAUG	HTER	13:	205 DA	IRYMA	ID DE	RIVE #	201,	SERM	ANTOWN,	MD 20874
Baltimore, permit. Pages 1 ar Department of Hea Important: If item; any injury or other once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F		20b. Place of D cemetery,	isposition (fi	Name of or other place	сө)	Da		20c. L	ocation - City or	Town, State
Page nent ant: b		`4 □Donation 5 □Other (Specify)	emoval from State	MOORE (CEMETE	RY	P	APR 2,	2004	DRA	PER, VIF	GINIA
alti mmit. spartr sport. y inje	1	21. Signature of Funeral Service License	29									RAL HOME,
o 89 e 2 8	1 1	Kalhx			16000	ANNAF	POLIS	ROAD	BOWIE	, M	D 20715	5
Physician /Medical Examiner and prival-transit and	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of)		r Dise	ase					
687 tificate												
Division of Vital Records, P.O. Box 68' Hospital or Attending Physicien: The law requires that the death certificat 24 hours after death. Funerel Director: After this certificate has been signed by the attending phy telly filled in by the funeral director, page 2 should be detached for use as the control of the control	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	3c. If yes, outcome of 1 Live birth 2 [4 Pregnant at time 9 Unknown	Fetal death	3 Ectopic		′				23d. Date of deli Month	very Day Year
that	y PI	Part II. Other significant conditions cor	tributing to death but r	not resulting in th	ne underlying	g cause giv	en in Part I.		23e. Did to	bacco u	use contribute to	the cause of death?
rds, luires righ	Q P	Pancreatitis							1 🗆 Y	'es 2	□No 3□Pro	bably 4 Unkno
cord w requir	Completed								24a. Was	20	24h Were au	opsy findings availa
I Re(The lav	Ę								autop		prior to d	ompletion of cause of 2□ No
Vital F iicien: Th certificate rector, pag	ပိ	25. Was case referred to medical					00 81	-4.0	1 X Yes		1 X Yes	2□ No
of Vita Physicien: this certific	0	ayaminar?	lospital:	2 ER/Outpa	atient 3 🗆	DOA Oth		-	Check only o		6 XOther (Spec	*
Of Phys arthis gral dir	H- 3	27. Manner of Death	28a. Date of Injury	28b. Tim	ne of	28c. Injun Wor			d. Describe h			(fy) AT SCE
ion or ading Fath.: After a funera	it	1 ▼ Natural 5 Pending 2 Accident investigation	(Month, Day Y	<i>'ear)</i> Inju	iry M		k? Yes 2 ∐l	No				
Division of Vital Records, sal or Attending Physicien: The law requires the safter death. I Director: After this certificate has been signed in by the funeral director, page 2 should be do	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (- At home, farm (Specify)	, street, fact	ory, office		28	f. Location (S City or Tow	itreet an n, State	d Number or Ru)	ral Route Number,
Di To the Hospital or within 24 hours aft To the Funerel Dir completely filled in	Medical (29a. Certifier 1 Certifying Physical Check only one) Medical Examination	sician: To the best of n ner: On the basis of ex and manner stated	camination and/c	leath occurre or investigation	ed at the tin	ne, date an pinion, dea	d place, an th occurred	d due to the d at the time, d	ause(s)	and manner as I place, and due	stated. to the cause(s)
To the within To the comp	Σ	29b. Signature and title of certifier	0 10		2	29c. License				29d. Dat	e signed (Month	, Day, Year)
		> Zalminell	al Al	Pro.			CME			MAR	CH 30,	2004
		30. Name and address of person who co		th (ttem 23a) (Ty	pe, Print)							
		ZABILLLAH	ALI	11.	1 Penn	Stre	et, E	Baltin	nore. N	larv	land 212	201
		31. Date filed (Month, Day, Year) MAR 3 1 2004	#2. Registrar's									

	1	State of Maryland / Department of Maryland / D		•	ne 200	09858	
Physiciar /Medica	1	1. Decedent's Name (First, Middle, Last) TOHN A HEARLY - BE 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month RC1	Day 19 Year 4c. County of Death	3. Time of Beath 4	
Funeral	ı	Bon Secours Hospital 5. Social Security Number 213-52-3451 6. Sex 1 № M 2 □ F 7. Age (In yrs. last birthday) 55 Yrs.	Baltimore	8. Date of Birth Month, Day May 1, 19		plece (State or Foreign intry) unk	
Director Maryland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo				10d. Inside City Limits 1X Yes 2 □ No	
th with the 23a or 28a	מותובר	10e. Street and Number 1217 W. Fayette Street	10f. Zip Code 21223		Citizen of What Cou		
iore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic svent, the Medical Examinar must be notified at	n by rune	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Vas Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F □ Yes 2₺ No Specify:		14. Race - Amer Black, White Specify: b1a	, etc. ack	
Maryland 21215-0036 d 2 should be filed within 72 hours all th and Mental Hygiene. 27 is marked other than "natural", or traumatic svent, the Medical Exami	Completed	(Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of workin OO NOT use retired)	unk 168	o. Kind of Business/li		
laryland 2 2 should be filled and Mental Hygi is marked other sumatic event, I	10 06	17. Father's Name (First, Middle, Last)	unk 18. Mother's Name			unk	
e, Mar 1 and 2 sh Health and sm 27 is m ther traum		Bon Secours Hospital 2000	g Address (Street and Number or Rura W. Baltimore Stre	et Baltin		.1223	
Itim		1 □ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 ☒ Other (Specify) in state	natory or other place) Name and Address of Facility Cate Anatomy Board				
Bal permi Impo Impo any is		marie de la la la la la la la la la la la la la	Itimore, MD 21201			Approximate Interval Between Onset and Death	
76(e be sicia e bur	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	uno de Ficienc	Y VIRI			
P.O. Box 687(nat the death certificate to d by the attending physisteleached for use as the to	by Physician/Medi		Ectopic pregnancy Other (specify)		23d. Date of delin Month	very Day Year	
cords, P. (w requires that the been signed by should be detace		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		co use contribute to	14	
	Completed			24a. Was an autopsy performed	24b. Were aut prior to c death? No 1 \(\subseteq Yes	opsy findings available ompletion of cause of 2 No	
ysician: Thysician: The secutificate director, pag	o pe	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Impatient 2 □ ER/Outpatier	26. Place of Death Other: 4 \(\) Nursing Hor		e 6 □Other (Spec	ifv)	
Vision of Vital Attending Physician: In death. Sector: After this certifice by the funeral director.	- 1	27 Manner of Death 1 X Natural 5 Pending investigation 2 Accident 28a. ate of Injury (Month, Day Year) 28b. Time of Injury			28d. Describe how injury occurred		
Divisio To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the th	Medical Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		and Number or Rural Route Number, ate)			
To the Hospital or within 24 hours affe To the Funeral Dir completely filled in	dical	29a. Certifier (Check only one) 1					
To the withing To the comp	Š	29b. Signature and title of certifier 2 200 2. June 1. June 1.0	29c. License number	. Des	Date signed (Month	0 Day, Year)	
		30. Name and address of person who completed cause of death (Item 23a) (Type.	BON SECOU	RS Hos	Sp. Bal	timere md.	
Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	boards				

State of Maryland / Department of Health and Mental Hygiene 2004 09859

		1	For State Registrar	State of Marylan		rtificate of L			g. No.	104	03003
	Physicia	in	Decedent's Name (First, Middle, Last) MADV UAMTT	TON				2. Date of Deat Month MARCH 2	Day	Year	3. Time of Death 2:40 A
	/Medic Examin	al -	MARY HAMILTON 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death				PIARCH 2	-	4c. County of Death		
	LXGIIIII		CATON MANOR NURSIN			BALTIMO	ORE	O Date of Birth		N/A	lana (State or Foreign
	Funeral Director		217 22 1331	7. Age (In yrs.)	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Dey, Aug. 26	Year)	Mary	lace (Stete or Foreign try) 1and
	land ow	}	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits								
U36 urs after death with the Maryland	s-f sh	ctor	Md. n/a	В	altimo	ore					1 NYYes 2 No
	h with the	Funeral Director	10e. Street and Number 1411 Battery Ave.			10f. Zip Code 212			0g. Citizen of U.S	.A.	
	d within 72 hours after death with the Marylan plens.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	2. Was Decedent Ever in U. Armed Forces? 1	S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2☐XNo	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ack, White,	
ည	72 ho natur	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dece	edent's Usual Occupa e kind of work done of DO NOT use retired	ation during most of work	ing	18b. Kind of E	Business/Ind	dustry
[Z]	within 72 ene. than na	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) +2	i	a Process			U.S.	F. & 0	J.
Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mental Hygiene.	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I		_{me)} Koch	
	should by nd Menta marked matic e	10	Edward I.	Cooper	10h Mail	ing Address (Street					(Code)
	h ar h ar r is trau		19a. Informant's Name/Relationship (Type David Hamilton	(Son)		Cliftmon			•		
Jre,	of Healt fitem 2 r other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	20b. P		osition (Name of ematory or other place			20c. Location		
Baltimore,	permit. Pages Department of Important: If it any injury or o		* 4 ☐ Donation 5 ☐ Other (Specify)	Mea		dge Memor					
Ba	Depariment in poor in		21. Signature of Funeral Service License	Frankler.		Name and Address MCCull 130 E.	ÿ <u>∺</u> PŏTynia Fort Ave	ık Funer: e. Balti	al Home more, 1	ер.А. Md. 21	1230
TA.			130 E. Fort Ave. Baltimore, Md. 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Onset and Death								
	Physician		omediate Cause (Final Isease or condition resulting in death)	Amal	FS	sollete					Olisot and Death
13	/Medical Examiner			Due to (or as a consequence of): Occident							
	- -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events		Due to (or as a consequence of):						
	and P-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):							
68760,	e be ex										
.89	rtificati ng phy s as the	Medical	IF FEMALE:	0	`						
.O. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1						ate of delive fonth	ory Day Year	
ds, P.(ires that th signed by t be detacl	uires that t signed by Id be detad							e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
Recor	he law requir e has been si age 2 should	Completed						24a. Was a autops perform	sy	were auto prior to co death? 1 \(\subseteq \text{Yes}	psy findings available mpletion of cause of
ta	ian: T	BeC	25. Was case referred to medical examiner?				26. Place of Deat				
Division of Vital Records, P.O. Box 68760, to Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and it in by the tuneral director, page 2 should be detached for use as the burial-transit	ng Physic dter this ce uneral dire	2	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28a. Date of Injury 28b. Time of Injury at Work?			ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
Divisio	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci			28f. Location (Street and Number or Rural Route Number, City or Town, State)		al Route Number,		
_	Hospital 24 hours Funeral stely filled	Medical Co	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, dea ation and/or	ath occurred at the tir investigation, in my o	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and r late and place	manner as s	tated. the cause(s)
	To the vithin.	Me	29b. Signature and title of certifier	0	447	29c. Licens	e number	2	29d. Date sign	ned (Month,	Day, Year)
			> sals	V	MD	レー	51467		3/2	7100	1
	18		30. Name and address of person who co	SHM1, 821	m 23a) (Typ	e, Print) Entaw &	+ Smite	30f i	Balta	me h	Day, Year) 1
7	St Regist	ate	31. Date filed (Month, Day, Year) MAR 3 1 2004	32. Registrar's Sign	акте	sporks/					

State of Maryland / Department of Health and Mental Hygiene 2 1 1 09860 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** SARA PRIEST HANSON March 26. 2004 6AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Meadows Glen Arm Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Days **Funeral** 1□M ¾√√F 212-05-1481 97 December 27,1906 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show affical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Glen Arm 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11630 Glen Arm Road 21057 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🕱 XVo Specify: White Specify: δ 3XXWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 7 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Colfege (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiene Important: if item 27 is marked other that any injury or other traumatic event, Int. 2006. Instructional Supervisor Company Telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Harrison Priest Bertha Ferry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gordon W Priest Jr Nephew 1501 Carrollton Avenue Baltimore, Maryland 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 XX Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 4/1/04 Baltimore, Maryland □Donation 5 □ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 Mny 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) numina clam **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Be Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12-months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 rmed2/ 2 No 1 ☐ Yes ector. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 No 4 V Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 🗌 Yes 1 🗀 Inpatient 2 ER/Outpatient funeral dir Medical Certification; To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director:: completely filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier who completed cause of death (ftern 23a) (Type, Print) 30. Name and address of person MO 0 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2004

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

			For State		State of M	aryland	•	artment of t tificate of		ina Mer		giene Reg. No		1 09861
			Registrar 1. Decedent's Name	(First, Middle, Las	st)					2.	Date of De.			3. Time of Death
	Physicia /Medic		LOIS	Harr	15						Marc	1,2	6 2004	1000
	Examin		4a. Fecility Name (If	-	street and number	Coini	01/	4b. City, Town, o	or Location of	f Death		4c.	County of Death	IMANIA
	Funeral		5. Social Security Nu	mber 6. S	1105011101 BX 7. A	ge (In yrs. la	ist birthday)	If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birt	th	9. Birth	nplace (Stete or Foreign
	Funeral Director		106-05	-1818 ¹	□M 21 X F	88	3 Yrs.	Months Days	Hours	Min. A	Date of Bird (Month, De UG. 11	,191	5	NY
	and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits
	Maryi if sho	tor	MD	BAI	_TIMORE		ВА	LTIMORE						1 ☐ Yes 2 ☐ No
	or 28s	Jirec	10e. Street and Num					10f. Zip Code				10g. Cit	izen of What Co	
	ited within 12 hours after death with the Maryland Hygiene. Hydiene. Inatural', or items 23a or 28a-f show ent, the Modical Examiner must be notified at	Funeral Director		MILL ROAI		Consis II C		A/ D		208	Van ar Na		14. Race - Ame	U.S.A.
	iter de	Fune	11. Marital Status 1 ☐ Never Marrie	d 2□ Marned	12. Was Deceden Armed Forces 1 ☐ Yes 2 💢 If Yes, Give	?		Was Decedent of I f Yes, specify Cub		Puerto Ric	an, etc.)	-	Black, White	
2	ours at	þ	3 X Widowed		If Yes, Give Year or Dates:			1□Yes 2∏X No	Specify:				Specify:	WHITE
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7	within then the M	dwo	Elementary/Secon	12 dary (0-12)	College (1-4or	5+)	BUYER	DO 1401 136 161/16	iu)			Т	UERKES	
	buid be tited with Mental Hygiene arked other that atic event, the	BeC	17. Father's Name (First, Middle, Last)					18. Mother	r's Name (F	irst, Middle,	Maiden	Sumame)	
<u>8</u>	permit. Pages I and 2 should be filed within 12 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: I tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	ToE	MARVIN				T	VIS	GERT					REICH
	h and h and 7 is m traum		19a. Informant's Na TDIIDV	me/Relationship (1 BEARD / 1				ng Address <i>(Str</i> ee DUFFIELD				_		(ip Code)
กั	Health tem 27 other tr		20a. Method of Disp	osition			ace of Dispo	sition (Name of natory or other pla		Date			ocation - City or	Town, State
2	Pages nent of int: If it iry or o		1 X Burial 2 ☐ • 4 ☐ Donation	Cremation 3 ☐ 5 ☐ Other (Specify]Removal from State y)	ANSF		NAH (AIT	Į.	M) 3/	29/04		BALTIMO	RE, MD
<u>a</u>	permit. Pages 1 a Department of Hez Important: If Item any injury or othe		21. Signature of Fur	neral Service Licer	1900		22	2. Name and Addr					N & BROS	
	20129		- Jul	1 Man	.0-	- d the death	Do not ont						KESVILLI	E, MD 21208 Approximate
			shock, or hear		plications that cause one cause on each	line.	. DO NOT ON	erotic		Litter 1/	ospiratory a	Aic	Mucan	Interval Between
89- I	hysician /Medical		disease or condition resulting in death)		a. Due to (or a			NOME	(av o	XIO V	13CU I	av	UNRUE	
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7	st ad	Examiner	Sequentially list con if any, leading to im cause. Enter Under Cause (Disease or i	tying	Due to (or a	s a consequ	ence of):							
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X D D	death certiff e attending ed for use as	Physiclan/M	23b. Was decedent in the past 12	months?	23c. If yes, outcom 1 Live birth 4 Pregnant	2 Fetal	death 3	Ectopic pregnand Other (specify)	су				23d. Date of deli Month	very Day Year
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ري ح	requires that the death cert een signed by the attendin hould be detached for use	by PI	Part II. Other signifi	,	^ .		lting in the u	nderlying cause g	ven in Part I.					the cause of death?
cords	w require been sig should b			reval	failuv	e					10	Yes 2	□ No 3 □ Pro	obably 4 Unknown
ပ္သ	as b	Completed									24a. Was autor		24b. Were au prior to death?	topsy findings available completion of cause of
Iai	Thate ate	CO	25. Was case referr	and to madical					OC Plane	of Doroth (6	1 Yes	21 No	1 ☐ Yes	21 No
5	ysician: Is certific director,	0 0	examiner?		Hospital: 1 ☐ Inpai	tient 2,21	R/Outpatier	nt 3 DOA Ot	her		Check only o		6 □Other (Spec	cify)
0	문 등 등	J: UC	27. Manner of Death	n 5 ☐ Pending	28a. Date of In	jury Jay Year)	28b. Time o	f 28c. inju			d. Describe			
<u> </u>	Attending or death. ector: After by the funer	catle	2 Accident	investigation					Yes 2 N		I I annaisan /	C		(G M
DIVISION	or At after d Direct in by	Certification:	4 Homicide	determined	288. Place of I	njury - At ho atc. <i>(Specify</i>	me, farm, sti	reet, factory, office		281	City or To	wn, State	na Number or Hu 3)	iral Route Number,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier		nysician: To the bes									
	the Ho in 24 I the Fu	Medical	one)		miner: On the basis and manner:		ion and/or in			th occurred	at the time,			
	To the within 2 To the complet	Σ	29b. Signature and	title of certifier	Page Mi	of che.	111		se number	11.0		29d. Da	te signed (Month	n, Dey, Year)
•			30 Name and add	1100 yo	completed cause of	death (Item	23a) (Type		00527	400		1110	well 2	0, 1104
			EDICE	A TORIN	Muldin	DW, K	11) E	1401 0	Id Co	our+	Roa	d	Randa	UStown,
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Registrar

			1 - For State Registrar	State of Maryland /		artment of Hertificate of L			ene 200	4 09862
	- 5	*	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medic		JAMES HE	NRY JOHNSON	SR.				24 2004	1.4
	Examin		4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of Death		4c. County of D	eath
	:: 	To the	1701 EUTAW PLACE	APT 707		BALTIMO			N/	
	Funeral Director		5. Social Security Number 6. Sex 10	M 2□F 7. Age (In yrs. last b		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Yeer)	Birthplace (State or Foreign Country)
	26		Usual Residence of Decedent					10.9	>-)	Maryland
	yland		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	B-fs	ctor	MARYLAND N/A	B <i>I</i>	ALTI	MORE				1 X Yes 2 No
	ith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	ath w		1701 EUTAW PLAC			2121			U.S.A.	
	ltam:	Funeral	Tr. Marian States	2. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
50	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖸 Divorced	1 ☐ Yes 2 ②ANo If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	BLACK
ž	be filed within 72 hours after death with the Maryland lat Hygiene. d other than "netural; or Itams 23a or 28a-f show event, the Madical Examinar must be notified at		15. Decedent's Educ	ation 16		dent's Usual Occupa		1	6b. Kind of Busine	
2	hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done done done done done done done done	uring most of work	ing		,
7	ad wit	Completed	8th grade		ENTRI	EPRENEUR			SELF EM	PLOYED
2	d be file antal Hy sed oth c event	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)	
<u>X</u>		ပ	CHARLES JOHNSON				ELLA H			
Maryland 21215-0036	~ ~ = =		19a. Informant's Name/Relationship (Typ			ng Address (Street a				
	t Health item 27 other tr		Michelle D. Johns 20a. Method of Disposition			5 CLOVILLE sition (Name of			RE MARY	LAND 21214
وّ	Pages nent of I int: If its iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	moval from State cemet	tery, crer	natory or other place	9)] -		
Baltimore,	it. P.		* 4 □ Donation 5 □ Other (Specify) 21. Signature 1 Funeral Service License			EMATORY	03-29			MARYLAND
n	permit. Pages Department of Important: If it any njury or o]	Marche 2	Vanell		Name and Address ILLIAM C F L206 W NOF			UNERAL HO	OME P.A.
			23a. Part1. Enter the disease, or complic	ations that caused the death. Do					st,	Approximate
	Physician		shock, or heart failure. List only one immediate Cause (Final		. 4	CEAL	1000	C = 0		Interval Between Onset and Death
155	/Medical		disease or condition resulting in death)	Due to (or as a consequence	a of).	GEAL				
	Examiner		Sequentially list conditions, b.	Due to (or as a consequence	Ro 1	VIC 01	BSTRUC	TIVE Y	2 LHONA	14
	D #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	e of):	D	ISEASE			
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last							
8760,	cate be executed physician and the burial-transit			Due to (or as a consequence	e or).					
98	phys s the	dicai	d.							
×	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy					23d. Date of	delivery
Box	death a atte	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
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ď.	The law requires that the tee by the bas been signed by the bage 2 should be detache		Part II. Other significant conditions conf	nbuting to death but not resulting	g in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ğ	w require been sig should b	ed t	CHRONIC OBSTRUL	TIVE LUNG	0	ISEASE		1 🗌 Yes	2 □ No 3 □	Probably 4 Onknown
Vital Records,	law re as be 2 sho	Completed by						24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
ř		E O						perform	ed? death	es 2 No
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	Physic this co	2	1 ☐ Yes 2 No	ospital: 1 Inpatient 2 ER/C			4 Nursing Fig		ce 6 Other (S	pecify)
Ē	ding P h. After t funera	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	. Time of Injury	Work	?	28d. Describe hov	injury occurred	
<u>S</u>	Attending Physician: In death. ector: After this certific by the funeral director.	catl	2 Accident investigation 3 Suicide 6 Could not be	On Olara distant Attant	-		es 2 □No	006 11 (0)		
Division of	or Attendation after deati	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	rarm, str	eet, factory, office		City or Town,	et and Number or State)	Rural Route Number,
_	ours a		29a. Certifier 1 Certifying Physi	cian: To the best of my knowled	ge death	occurred at the time	e date and place	and due to the car	se(s) and manner	as stated
	24 h 24 h Fur etely	edical	(Check only 2 Medical Examin one)	er: On the basis of examination a and manner stated.	and/or in	vestigation, in my op	inion, death occur	red at the time, dat	e and place, and o	ue to the cause(s)
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Me	29b. Signature and title of certifier			29c. License		29	d. Date signed (Mo	onth, Dey, Year)
	1		1 lister Co	MD		DA	3472		3/26	104
	11		30. Name and address of person who co	ppleted cause of death (Item 23a	a) (Type,	Print)				
		_	PETER C.	npleted cause of death (Item 23a) 7 (AN G M) 92. Registrar's Signature	24	25EUTA	w fLAC	& BAL	TIMORE	21217
	Sta		31. Date filed (Month, Day, Year)	22. Registrar's Signature	1	M. a				
	Regist	rar	MAR 3 1 2004	State of	Ser Se					

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2004 CHARLES CARVEN JOHNSON SR. larch 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltomone Health care 9 NR Stomme If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 214-70-9012 SEPT 8 Director 46 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at 1 XYes 2 ☐ No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 208 MOUNT STREET 21229 U.S.A. r than "natural", or items 23a the Medical Exeminer court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ANo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: Specify: Specify: BLACK Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIRECT WORKER unknown STATE OF MARYLAND marked other item 27 is marked other other traumatic event, or and 2 should be fit of Health and Mental Hy, item 27 is man 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ SAMUEL JOHNSON JR MARGARET E JOHNSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSALYN JOHNSON/Wife 208 Mount St., Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Important: If it any injury or o Department of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 03-31-04 BALTIMORE, MARYLAND permit. 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee 1206 W NORTH AVENUE 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death neumona Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): physician Completed by Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown phoods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t firector, page 2 s autopsy performed? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred the Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 053642 cause of eath (Item 23a) (Type, Print) 30. Name and address of person who completed Rown Blud PUB 303 (AC) Ut34 60 31. Date filed (Month, Day, Year) State Registrar MAR 3 1 2004

DHMH 17 Hev 1/2001

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

1 - For State Registrar

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Baltimo	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	Porchet
- 8			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Breau Due to (or as a con
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,60,	be executer sicien and buriat-trans	ai Exam	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 points? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 Live birth 2 1 4 Pregnant at time 9 Unknown
al Records,	n: The law requires the case of the case o	Completed by		Similaring to dearn but no
<u> </u>	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:
ion of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea
Divis	i or Atterateraterateraterateraterateraterater	ertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S)
\$	To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the fi	dical C		nysicien: To the best of my miner: On the basis of exa and manner stated.
	To the Complete Compl	Me	29b. Signature and little of certifier	W
	Ŋ		30. Name/and address of person who	completed cause of death () 90)

31. Date filed (Month, Day, Year)

Anja Kaarina Kusler March 28 2004 March 28 2004 4a. Fecility Name (If not institution, give street and number) Anne Arundel Medical Center Annapolis Anne Ar	3. Time of Death		
ner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea	10:57 p M		
	4c. County of Death		
	undel		
5 Social Security Number 6 Say 7 Age (In vrs. last hinthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Rich	thplace (State or Foreig		
016-36-8737 One of the control of	nland		
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limit		
	1 □ Yes XXN		
MD Anne Arundel Edgewater 10e. Street and Number 10g. Citizen of What Co			
10e. Street and Number 10f. Zip Code 10g. Citizen of What Co	ouritry r		
124 Riverton Place 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Dever Married} \) 2 \(\text{Marined} \) Amried 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ame Black, White	dana tadian		
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Ame			
3 ☐ Widowed 4 ★ Doivorced If Yes, Give Year or Dates: Specify: What Spe	ite		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Dept. of A	/Industry		
Elementary/Secondary (0-12) College (1-4or 5+)			
5+ Loan Specialist Dept. of A	griculture		
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)			
Uljas Jalmari Turkki Terttu Helen Collan			
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,	Zip Code)		
Karina Holland (Daughter) 1362 Towson Street, Baltimore, MD 21230)		
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or cemetery, crematory or other place)	Town, Slate		
1 Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) Metro Crematory 3/30/2004 Baltimore,	MD		
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis MD 214	.01		
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life.	Approximate		
In-modiate Course (Final	Onset and Death		
disease or condition resulting in death)	Il month		
Due to (or as a consequence of):			
Sequentially list conditions, b. Oue to (or as a consequence of).			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of):			
that initiated events that initiated events c. Due to (or as a consequence of):			
d			
d. IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 Dive birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of de Month 1 Month 2 Month 2 Month 3 Month 3 Month 4 Month			
FFEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy	,		
	Day Year		
9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown 9 Unknown			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	the cause of death?		
	robably 4 Unknow		
24a. Was an autopsy performed? death?	utopsy findings availabl		
autopsy performed? death?	completion of cause of		
1 Ves 2 2 No 1 Yes	2 10		
1.00 2200			
25. Was case referred to medical examiner?			
25. Was case referred to medical examiner? O 1	cify)		
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death 28. Date of Death	cify)		
25. Was case referred to medical examiner? O 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Special Page 1) No Special Page 1) No Special Page 1 Nursing Home 5 Residence 6 Other (Special Page 1) No Special Page 1) No Special Page 1 Nursing Home 5 Residence 6 Other (Special Page 1) No Special Page 1) No Special Page 1 Nursing Home 5 Residence 6 Other (Special Page 1) No Special Page 1) No Special Page 1 Nursing Home 5 Residence 6 Other (Special Page 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Other (Nursing 1) Nursing Home 5 Residence 8 Othe	cify)		
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) Cher: 4 Nursing Home 5 Residence 6 Other (Specific Residence) 27. Manner of Death 28. Date of Injury 2. See Describe how injury occurred.			
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 27. Manner of Death The Natural 5 Pending Investigation 3 Suicide 6 Could not be learninged 28b. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or R			
25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpalient 2 ER/Outpatient 3 DOA 26. Place of Death (Check only one) 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? M 1 Yes 2 No 28d. Describe how injury occurred	ural Route Number,		
25. Was case referred to medical examiner? 1	ural Route Number, s stated. e to the cause(s)		
25. Was case referred to medical examiner? 1	ural Route Number, s stated. to the cause(s) h, Day, Year)		
25. Was case referred to medical examiner? 1	ural Route Number, s stated. e to the cause(s)		

32. Registrar's Signature

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

;		1 - For State Registrar	State of Ma		ertificate of			g. No. 200L	09865
		1. Decedent's Name (First, Middle, La	ist)				2. Date of Death		3. Time of Death
Physici /Medi		Dawn Nicole Moore	2				Month March 2	Day Year 25, 2004	22:25 P M
Éxamir		4a. Facility Name (If not institution, give	re street and number)		4b. City, Town,	or Location of Deat	h	4c. County of Dea	th
		Washington Count			Hagers		15	Washingt	on
Funeral Director		,	Sex 7. Age 1 □ M 2 🔯 F	(In yrs. last birthd	Months Days		(Month, Day, 1	Year) 9.78ir	thplace (State or Foreign ountry) Maryland
_		Usual Residence of Decedent		10			July 9,	1703	Maryland
ahow	_	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
with the Marylan or 28a-1 ahow	Director	Maryland Freder	ick	Frede	1	<u> </u>	1		1 ☐ Yes 2√ No
with t	ă	10e. Street and Number 4961A Jefferson P	± 1		10f. Zip Code	700	10	g. Citizen of What C	
ns 23e	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S.		703 Hispanic Origin? (S	pecify Yes or No-	U.S.A	
after dea or Items	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕅 No		Was Decedent of If Yes, specify Cui		o Rican, etc.)	Black, Whi	
ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 ☒ No	Specify:		Specify:	White
"natu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(G	cedent's Usual Occu	during most of wor	rking 16	6b. Kind of Business	/Industry
withir ene. then	를	Elementary/Secondary (0-12)	College (1-4or 5+)) ""	o. DO NOT use retire Student	9d)		College	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-1 ahow any injury or other traumatic avent, it a Medical Examble at most traumatic avent, it a Medical Examble at most traumatic avent.	Be Co	17. Father's Name (First, Middle, Last,)		beatene	18. Mother's Nar	ne (First, Middle, Ma		
Alenta Alenta rked ric av	0 B	P. Allen Moore				Kimber	· ·		
2 should and Men Is marks aumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Stree			City or Town, State, .	Zip Code)
and ealth m 27		P. Allen Moore/Fa	ther	3824	Jefferso	on Pike,		, Maryland	1, 21755
Pages 1 nent of H int: If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State		sposition (Name of rematory or other pla		Date 20	c. Location - City or	Town, State
t. Pa rtmen rtant: njury		`4 □Donation 5 □Other (Specif	•	St. Luke	e's Cemete)/2004	Feagavill	e, Maryland
Departitus Departitus Importitus any injustration		21. Signature of Funeral Service Licer	m & mith	2	22. Name and Addr	,	D 1 11		st Church Stree
		23a. Part1. Enter the disease, or com	plications that caused th	ne death. Do not			Funeral Hor		Approximate
Physician		Immediate Cause (Final	one cause on each line.		N		,	,	Interval Between Onset and Death
/Medical		disease or condition resulting in death)	a. Due to (or as a	7400	uries				
Examiner		Sequentially list conditions,	b						
pe is	Examiner	if any leading to immediate cause. Enter Underlying	Due to (or as a	connequence of):					
executed in and ial-transit	хаш	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
	_			31).					
certificate be nding physicie use as the bur	edlo		d						
h cert endin	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1□Live birth 2		2			23d. Date of del	ivery
e death he atter ied for u	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at tir		3 □Ectopic pregnand 5 □ Other (specify) _	.y 		Month	Day Year
that the de ned by the detached	Phy	9 ☐ Unknown Part II. Other significant conditions of		and an adding to the			Too. Bid. I		
= Φ ∪	by	raitii, Ottor significant conditions o	omnoung to death but	not resuming in the	i underlying cause gi	ven in Part I.	1 Tes	u	the cause of death?
S C 0							-		
v requires been sign should be	etec						24a. Was an		topsy findings available
e law requires has been sign je 2 should be	mpletec				 -		autopsy performe	d? death?	completion of cause of
The law requires ate has been sign page 2 should be	e Completed	25. Was case referred to medical				00 81	performe	d? death?	2 No
The law requires ate has been sign page 2 should be	o Be	25. Was case referred to medical examiner? 1 ↑ Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 S★ER/Outpat	ient 3□ DOA Ot	her	performe 1 Yes 2 th (Check only one)	d? death? No 12 Yes	2 No
Physician: The law requires this certificate has been sign ral director, page 2 should be	To Be	examiner? 1 ∑ Yes 2 □ No 27. Manner of Death	28a. Date of Injury	28b. Time	ient 3 UOA	her: 4 🗆 Nursing H	th (Check only one) The sidence of the sidence of	d? death? No 1 X Yes te 6 Other (Speciniury occurred	2 No
ding Physician: The law requires h After this certificate has been sign funeral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)	Year) 28b. Time Injun	of 28c. inju	her: 4 🗆 Nursing H	performe 1 12 Yes 2 [th (Check only one) ome 5 [] Residence	d? death? No 100 Yes ce 6 □Other (Speciniury occurred mater vah. d	2 No
or Attending Physician: The law requires er death irector: After this certificate has been sign to the funeral director, page 2 should be	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day)	28b. Time Injun 1:30	of 28c. Inju Wo M 1	her: 4 Nursing H	performe 16 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how first one) 28d. Coastion (Check only one)	d? death? No 10 Yes the 6 □Other (Specinitury occurred material of the country	2 No Sily) sub-dright struck Partial Route Number.
pital or Attending Physician: The law requires urs at er death. sral Director: After this certificate has been sign illed in by the funeral director, page 2 should be	Certification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day) 3 -2.5 - 04 28e. Place of Injury building, etc.	28b. Time Injun 2 2 3 0 7 - At home, farm, (Specify)	of 28c. Injuny Mo P M 1 E street, factory, office	her: 4 □ Nursing H ry at rk?]Yes 2 ∭ No	performe 1 (Check only one) ome 5 (The sidence) 28d. Describe how 1 (Sidence) 28d. Location (Sidence) City or Town.	d? death? INO 1AYes De 6 Other (Specinjury occurred mater vish of the control o	2 No Sity) s which struck (enturned. Iral Route Number, 1826 Rt 464
ttending Physician: The law requires death. ctor: After this certificate has been sign / the funeral director, page 2 should be	ertification; To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying Ph	28a. Date of Injury (Month, Day) 3 -25 - 04 28e. Place of Injury	28b. Time Injury 12 5 0	of 28c. Injunction of 28c. Injunction of 28c. Injunction of 1 Control	her: 4 ☐ Nursing H ry at rk?] Yes 2 ∭ No	performe 16 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how conditions of the conditions o	death? No 1AYes to 6 Other (Specinjury occurred mater vehicle and output of the state) Fry Rd State) Fry Rd	2 No sity) such in struck (enturned. ral Route Number. ivean Ri 464

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L(NG LI, M)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

March 26, 2004

State Registrar

MAR 3 1 2004

m D

O.C.M.E.

State of Maryland / Department of Health and Mental Hygiene 09866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Martin 4450m HaHie 2004 /Medical Facility Name (If not institution, 4b. City, Town, or Location of Death give street and number) 4c. County of Death **Examiner** BAUTIMORE If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 Hours 6444 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "netural", or items 23a or 28e-f shot traumatic event, the Medical Examinar must be rollined at BAUTIMORE 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country
U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married I∏Yes 2 If Yes, Give 2 ☐ No Baltimore, Maryland 21215-0020 Specify: BLACK 1 ☐ Yes 2 ☐ No Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 5 Department of Health end Mental Hygiene. Important: If them 27 is marked other than "ne any injury or other traumatic event." PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CRAW FORD William SR. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, ELDERON AVE. ANTHONY WILLIAMS NEPHEN 20b. Place of Disposition (Name of cemetery, crematory or other 20a. MetHod of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ORK ROAD BATTIMORE, MO 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner within 24 hours efter death. To the Funerel Director: After this certificate has been signed by the ettending physician end completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 triknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: A Nursing Home Certification: To 1 ☐ Yes 2□Ak 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 - Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certiffer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Rowen Blvd, Ba Form, 2601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		For State Registrar	State of Maryla		artment of H			iene g. No. 2001	+ 09867
		Decedent's Name (First, Middle, Las	1)				2. Date of Deatl		3. Time of Death
Physic /Med		JANICE EILE	EN MI	LLER	-		MARCH	29 200	4 12.50 PM
Exami		4a. Facility Name (If not institution, give HARIBOR HOSPITA			4b. City, Town, or BALTIN	Location of Death		4c. County of Dea	
Funeral Director		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday) 2 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct.06	Year) C	rthplace (State or Foreign country) ryland
		Usual Residence of Decedent					000.00	1791 110.	
rylan show	_	10a. State 10b. County n/s		City, Town or Lo Baltimo					10d. Inside City Limits 1 ☑ Yes 2 ☑ No
Ba-fs	Director		<u> </u>				14	Og. Citizen of What C	1
death with the Maryland ms 23a or 28a-f show Emust be notified at	al Dire	10e. Street and Number 3816 Second St	reet		10f. Zip Code 2122	5		U.S.	•
<u> </u>	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	'	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 【X No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
72 ho	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup	ation during most of worki	ing	16b. Kind of Busines	s/Industry
Vithin 72 hours affered in a feet of the "naturel", or the Medical Examination of the Medical Examinat	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired usewife	1)		Homemake	er
	To Be Co	17. Father's Name (First, Middle, Last) Vincent	Barrett			18. Mother's Name Eileen	(First, Middle, N	Maiden Sumame) Smith	1
4 4 B B		19a. Informant's Name/Relationship (1) John M. Miller St			ng Address (Street 6 Second	and Number or Rura Street, I	al Route Number, Baltimor	City or Town, State, e, Md. 212	Zip Code) 225
Baltimore , permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other pone.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State		osition (Name of matory or other place Crematory	(8)	Date :	20c.Location - City o Baltimore	
Dalti permit. I Departm Importa		21. Signature of Funeral Service Licer	see DelaM	11	2. Name and Addre McCully 237 E	ss of Facility 7-Polynial Patansco	Funera	l Home P.A ltimore, N	A. Md. 21225
14		23a. P. 11. Enter the disease, or composition, or heart failure. List only	plications that caused the de	eath. Do not ent	ter the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between
Priysician	_	Indediate Cause (Final ease or condition	CEREBROY			CIDENT			Onset and Death DAJS.
/Medica Examine		resulting in death)	Due to (or as a cons	sequence of):	HERN	IATION			4 DAYS.
	Je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons		ricici.				
8760, rate be executed physician and the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a cons	equence of):					
8760, ate be ex hysician the burial	dical E		d	31).					
68 tificat ig phy as the	ledic		-						
Records, P.O. Box 6: The law requires that the death certific the has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Who 9 □ Unknown	23c. If yes, outcome of prediction 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnancy □ Other (specify) _			23d. Date of d Month	elivery Day Year
that the operation of the detaction		Part II. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
cords w requires been sign	ed by						1 □ Ye	s 2 No 3 1	Probably 4 Munknown
Division of Vital Records, for Attending Physician: The law requires that dath. Director: After this certificate has been signed in by the tuneral director, page 2 should be a	Completed			· · · · · · · · · · · · · · · · · · ·			24a. Was a autops perform	y prior to	autopsy findings available completion of cause of
ital	BeC	25. Was case referred to medical examiner?		-	- 4-	26. Place of Deat			
of V hysic his ce	10	1 ☐ Yes 2 ☑ No		ER/Outpatie	-	4 Nuising no		ence 6 Other (Sp	pecify)
Vision of Vita Attending Physician: r death. ector: After this certifical by the funeral director,	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe ho	w injury occurred	
Division or attending Phater death. Director: After the in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	9 29a Place of Injuny - A	t home, farm, st			28f. Location (St City or Town	reet and Number or i	Rural Route Number,
Division To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the			nysician: To the best of my			me, date and place			as stated
the Hos in 24 ho he Fun pletely	edical	(Check only one)	niner: On the basis of exam and manner stated.	ination and/or in	ivestigation, in my o	ppinion, death occur	red at the time, d	ate and place, and de	ue to the cause(s)
To t To t com	Σ	29b. Signature and title of certifier 9 4 wrgusiu	M.D.		RES	800	1	9d. Date signed (Mo. $3/30/00$	
1		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print) HAR	BOR HE	SPITAL		
	tate	31. Date filed (Month, Day, Year)	32. Registrar's Si	onature		١٠٠١ , ١٥٠١	-In IORC	110212	-3
Regis		MAR 3 1 2004	harman	B,	books				

			Please Type or State o	Print in Bla f Maryland				•		•	
			1 - State RegistAMEND ITEM #2 PEL: PHY G8						Reg. No	71111	09868
H	Physicia	an	1. Decedent's Name (First, Middle, Last)				•	2. Date of D Month		25,2004	3. Time of Death 00:32
	/Medic		Ros 4a. Facility Name (If not institution, give street and nur		ekins	4b. City, Town, o	or Location of Dea			County of Dea	
	Examin	er	Sinui Hospital of	Balkin	orc	Backin		h		,	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hr Hours Mir	(Month, D	irth Day, Year	9. Bi	thplace (State or Foreign
	Director		214-22-1819 1 M 2 F	82	Yrs.			9-2	-192	1	Va
	and wo		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	ation					10d. Inside City Limits
	Mary	tor	Md N/A	Bal	to						1 X Yes 2 ☐ No
	or 288	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What C	ountry?
	23a c	ralD	2806 Mohawk Avenue			21207				S A	
	er deg	Funeral	Armed Fo		13. V	as Decedent of I Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	Specify Yes or Neto Rican, etc.)	10-	14. Race - Am Black, Whi	
2	should be filed within 72 hours after death with the Maryland nd Mantal Hyglene. I marked other than "natural", or Items 23s or 28s-f show umatic event, the Medical Examinar must be notified at	by F	1 ☐ Never Married 2 📉 Married 1 ☐ Yes If Yes, Giv 3 ☐ Widowed 4 ☐ Divorced Year or D	/A	1	☐ Yes 2X No	Specify:			Specify:	Black
5	r2 hou		15. Decedent's Education (Specify only highest grade completed)	1	6a. Deced	ent's Usual Occup	pation	orkina	16b. K	(ind of Business	Industry
7	ithin 7 Ben "r Med	Completed	Elementary/Secondary (0-12) College (1			ONOTuse retire 1y Elect	during most of w	Sining	We	stingho	use
7	Hogier Her th		12th grade 17. Father's Name (First, Middle, Last)	N/A A	Docino			ame (First, Middl	la Maida	Sumame)	
<u>a</u>	d be findal Head of	Be c	Richard Briggs					Boisseau		, oumanio,	
	should nd Me mark	2	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	Address (Street	and Number or F			or Town, State,	Zip Code)
Z	alth a		George W. Meekins - Hus	sband	2806	Mohawk	Avenue	Balto.	Md 2	1207	
ב ב	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, Ite Medical Examinat must be notified at ancie.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from	0000	e of Dispos etery, crem	ition (Name of atory or other pla	ce)	Date	20c. L	ocation - City o	Town, State
Ĕ	Pag ment ant: h		'4 Donation 5 Other (Specify)	Gar			Vet 3-3				11s, Md
	permit. Depart Import any in		21. Signature of Fulleral Service Licensee	/	22.	Name and Addre		March F			, Md 21215
	40369	_	23a. Part1. Enter the disease, or complications that of	aused the death. [Do not ente	r the mode of dvi				e baito	Approximate
			shock, or heart failure. List only one cause on e	ach line.		,	3,	,			Interval Between Onset and Death
	Physician /Medical		resulting in death)	CO as a consequen							
	Examiner		Conversion for conditions	nohus	emo	2					
١.	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequen	ce of):						
	be executed ician and burial-transit	Examiner	that initiated events c.	or as a consequen	ice of):						
Ď.		<u>65</u>		,	,						
00	death certificate e attending phys id for use as the	Physician/Medic	d.								
O	th cert endin r use	an/M	230. Was decedent pregnant	come of pregnancy		Ectopic pregnanc	٧			23d. Date of de	
	0 0	sicia		ant at time of death		Other (specify) _	,			Month	Day Year
7.	requires that the een signed by the		Part II. Other significant conditions contributing to d	eath but not resultir	ng in the un	derlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute I	o the cause of death?
gs,	w requires that been signed b should be deta	d by						15	Yes 2	□No 3□P	robably 4 Unknown
ecords,	> 0 2	olete						24a. Wa		24b. Were a	utopsy findings available
r	The tay	Completed						aut per 1 Yes	opsy formed? 2.□No	death?	completion of cause of
VITA		Be C	25. Was case referred to medical examiner?					eath (Check only			
>	or Attending Physician: siter death. Director: After this certific in by the funeral director.	ပို	1 ☐ Yes 2 ☑ No Hospital: 1 ☑		/Outpatien	3 DOA		Home 5 Re			ecify)
	ding F h. After funera	lon:	Taratulai 5 1 onding	of Injury 28 th, Day Year)	Bb. Time of Injury	28c. Inju Wo M 1	ryat irk?]Yes 2 □No	28d. Describe	now inju	iry occurred	
ISION	al or Attendia after death. I Director: Al d in by the fu	fical	3 ☐ Suicide 6 ☐ Could not be 28e. Place	of Injury - At home	, farm, stre						ural Route Number,
Ē	al or/	Certification:	4 Homicide determined build	ing, etc. (Specify)				City or 1	own, Stat	9)	
	ospita hours unera ily fille		29a. Certifier 1 Certifying Physician: To the								
	To the Hospital or within 24 hours after To the Funeral Div completely filled in	Aedical	one) and man	ner stated.		20a Lisan	an aumhor		304 D	ate signed (Mon	
	To Toon	Σ	29b. Signature and title of certifier	wo		29c. Licen:	7693		W 1	With 25	7, 2004
	\wedge		30. Name and address of person who completed cause of the state of the	se of death (Item 21	Ra) (Tune	Print)		2	,- 00		, ,
	1)		African (1. Proplet)	My S	in al	Hospi	tol of	Baltin	ion		
	Str	ate	31. Date filed (Month, Day, Year) 32. F	Registrar's Signature	0		· · · · · · · · · · · · · · · · · · ·				

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 09869 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 26-2004 March 9.35 am Physician ATHERINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner BALTIMORE CENTER HOSPITAL HARBOR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. May 20, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 217 05 6806 1 ☐ M 2 🖸 F Maryland 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show the Medical Examiner must be notified at tx Yes 2 □ No N/A Baltimore Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21225 U.S. 1100 Church Street Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ŏ 1 ☐ Yes 20 No Specify: White Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12th of Health and Mental Hygis filam 27 is marked other r other traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bernard Wentker Anna Zeck ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21225 Elizabeth Mohl / Daughter 1100 Church Street Important: If itan, any injury or othe, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Bayview Crematory 3/30/2004 Baltimore, Maryland permit. Departm 22. Name and Address of Facility 21. Signature of Funerat Service Licensee Gonce Funeral Service, P.A. 23a. Part . Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Kespiralon Physician /Medical Due to (or as a consequence of): 1 DUSS **Examiner** neumonia Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of Examiner physician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ HearT Congestive 1 Yes 2 No 3 Probably 4 Unknown cate has been signated to page 2 should to Completed Dementia 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 SInpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Alter t Certification: 1 Natural 5 Pending investigation s after deau rel Director: After 1 Yes 2 No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel within 24 hours a To the Funerel Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier herma in Teru 001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Center, Baltimore Sharma; Harbor Kishore 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 1 2004 Registrar

			For State Registrar	State of Maryland	•	irtment of H <i>tificate of I</i>		lental Hyg	giene leg. No. 200	4 09870
	Physicia	an	Decedent's Name (First, Middle, Last)	Μ.		MERSO	N	2. Date of Dea Month	Day Year	110 6-C-D M
	/Medic	al	4a. Facility Name (If not institution, give st				Location of Death	MARCH	2.8 200 4c. County of De	9
	Examin	eı	HARBOR HOSPI		C-		TIMORG		N/A	
	Funeral		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. la M 283 F 83	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8 Date of Birth (Month, Day April 2	9. Bi	rthplace (State or Foreign Country) Maryland
	Director		Usual Residence of Decedent		T 1 -			INDITE Z	0,1320	
	show	2	10a. State 10b. County Maryland Anne A		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 No
	the N	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?
	23s or	ai D	420 Waverly Avenu			2122			U.S.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "neturel", or items 23a or 28a-f show mit portant: If item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be multipled at Once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3X Widowed 4 Divorced	 Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 		Was Decedent of H f Yes, specify Cuba 1 Yes 20 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify: W	ite, etc.
215-0036	thin 72 ho e. an "netur Wedical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. l		ation during most of work d)	ing	16b. Kind of Busines	·
2	iled wil Hygien Her th		8th 17. Father's Name (First, Middle, Last)		Hom	emaker	18, Mother's Nam	e (First, Middle,	Own Home	9
auc	id be fental hed of	To Be	Granison	Lowman			Mar	garet St	evens	
Maryland	2 shou and N is mai		19a. Informant's Name/Relationship (Typ						r, City or Town, State	
e, Z	1 and Health em 27		Patricia Brady /			averly Averition (Name of matory or other place		Date Date	20c. Location - City of	
MO	Pages nent of nt: If it		1 ☐ Burial 2 ☆ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State		crematory	2 /20	/2004	Baltimore	, Maryland
Baltimore,	permit. Departm Imports any inju		21. Signature of Funeral Service License	. Diggot	H 40	001 Ritch	ie Highwa	y Bal		ce, P.A. ryland 21225
ast			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death e cause on each line	. Do not ent	er the mooe of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	dicai	d	- Acute K	enal	failure				-
Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetat 4 □ Pregnant at time of de	death 3	Ectopic pregnance Other (specify)	у		23d. Date of d Month	elivery Day Year
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ŝ	The law requires that ite has been signed b page 2 should be dek	þ	Part II. Other significant conditions con	tributing to death but not resu	Ilting in the u	inderlying cause giv	ven in Part I.			to the cause of death? Probably 4 Unknown
Vital Record	The law requate has been page 2 should	Completed							an 24b. Were prior to death?	
/ital		BeC	25. Was case referred to medical examiner?			0	26. Place of Dea			
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	nding l ath. r: After e funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	Injury	of 28c. Inju Wo M 1	rk?]Yes 2□No			
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, st	reet, factory, office		28f. Location (5 City or Tow	Street and Number or vn, State)	Rural Route Number,
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (sician: To the best of my knowner: On the basis of examinat and manner stated.						
	To the within To the comple	Me	29b. Signature and title of certifier	. MS		29c. Licen			29d. Date signed (Mo	
	· A		Dr T Said			RG		UMMALK	9 //	2004
	1		30. Name and address of person who co	empleted cause of death (Item PITAL CENTRO				TREET.	BALTIMO	RE M. D. 21225
		ate	31. Date filed (Month, Day, Year) MAR 3 1 200	32-Registrar's Signa	ture					
	Regist	rar	MALETA OF T COR	" Par Beren K	X A	Sec. 1				

			1 - For State Registrar	State of M	arylan		artment rtificate			and M		giene	-201	04	0987	7_1
	Physici /Medio Examir	cal	Decedent's Name (First, Middle PEARL A. Facility Name (If not institution,	Moskow			4b. City, T	own, or	Location o	of Death	2. Date of De. Month WARCH	Day 2		ar 04 Death	3. Time of Death	4
	Funeral Director		5. Social Security Number 145-03-2018	6. Sex 7. A	ge (In yrs.	last birthday) 5 Yrs.	II Under 1 Months		If Under 2 Hours		8. Date of Birt Month Da APR . 12	th	BACT 8		oce (State or Foreig	gn
	the Maryland 28a-f show puffied at	ector	Usual Residence of Decedent 10a. State 10b. County MD BA 10e. Street and Number	LTIMORE	10c. Cit	y, Town or Lo	IMORE					10- 0%	zen of Wha		d. Inside City Limit 1 ☐ Yes 2 🙀 N	
36	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23s or 28s-1 show wit, the McGircal Examinet must be maiffied at	y Funeral Director	4204 OLD MILFO 11. Marital Status 1 💢 Never Married 2 🗆 Marrie	12. Was Decedent Armed Forces' ed 1 Yes 2 X	Ever in U.	1	Was Decede	ent of His fy Cubar		208 gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, V	America Vhite, e	U.S.A.	
21215-0036	d within 72 hours giane. er than "natural", ine Medical Ex.	Completed by	3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12) 12		5+)	16a. Dece (Give life.	dent's Usual kind of work DO NOT use RETARY	Occupa	tion uring most	of worki	ng		nd of Busine	ess/Indu	estry	
ryland	should be file nd Mental Hy marked othe imatic evant,	To Be C	17. Father's Name (First, Middle, L HARRY				KOWITZ		ROS	SE	(First, Middle,				SERBER	
re, Mary	Health a tem 27 tem 27 te	1	19a. Informant's Name/Relationsh HELEN BROWN / 20a. Method of Disposition	SISTER	20b. P		COYL	E RC)AD #2	202	- OWING	S MI		MD 2	21117	
altımore,	permit. Pages Department of Important: If i any injury or o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service to	ecify)		TH DAV:	ID MEM	ORIA	AL :	3/29	/2004 L LEVIN	KEN	ILWOR	TH,	NJ	
n	90 E 9		23a. Pent Enter the disease, or shock for heart lailure. List of Immediate Cause (Final	complications that cause only one cause on each I	d the death	8	3900 R	EIST	ERST(I NWC	ROAD -	PIKE		E, N	Approximate nterval Between Onset and Death	
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10 U	ng Phy fter this meral d	ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig:	ation		ER/Outpatien 28b. Time ol Injury		Other	4 🗆 Nur	sing Hon	Check only or ne 5 Resid	lence 6		ipecify)		
DIVISION	To the Hospital or Attendi within 24 hours after death. To tha Funeral Director: A completely filled in by the to	O	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	ned 286. Place of in building, el	c. (Specify	()					281. Location (S City or Tow	m, State)				
	the Hosp thin 24 hou tha Fune mpletely fi	Medical	29a. Certifier (Check only one) 2 Medical E 29b. Signature and title of certifier	Physician: To the best xaminer: On the basis of and manner st	it examinat	wledge, death tion and/or inv	estigation, ir	the time n my opi License	nion, death	place, a	d at the time, o	date and	place, and o	to the	ne cause(s)	
	70		30. Name and address of person w		(Sici		Do	057	0950			MAR	signed (Mo	27	2004	
e,	Sta Registr		1 A	75-U 74- 32. Pogistr 2004	75 E rar's Signal	AST FI	RNAC	EB	RANC	ed k	20,00	EN B	VRM	e 1	NO 210%	20

State of Maryland / Department of Health and Mental Hygiene State Registra MEND ITEM #4b PER PHY G830 4/12/04 Spertificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 **Physician** 2004 9:56 p. M 24 Bertha McCrav /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 6820 Lenbern Road N/A BALTIMORE Date of Birth (Month, Day, Year) 9-30-1902 9. Birthplace (State or Foreign Country)
N.C. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 □ F 220-36-1464 Director 101 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State od 2 should be filed within 72 hours after death with the Marylan than Amerial Hygiene. 27 is marked other than "natural", or liema 23e or 28e-1 show treumatic event, the Marylical Examiner must be netitied at 1 Yes 2 □ No Director N/A Balto 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 USA 6820 Lenbern Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No tf Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Black 1 □ Yes 2 No Maryland 21215-0036 Specify þ 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) N/A Elementary/Secondary (0-12) Homemaker Domestic Engineer 3rd grade

17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Hillard Harris Samatha Brower 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 le any injury or other treu once. Eugene James - Grandson 6820 Lenbern Road Balto, Md 21207 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4/02/04 Southern Pines, NC Woodlawn Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. 4300 Wabash Avenue Balto, Md 21215 Approximate Interval Between Onset and Death mmediate Cause (Final issection ABdomINAL ADRIA ANEURYSM **Physician** disease or condition resulting in death) /Medical ARTERIOSCLERO-CARDIO VASCULAR DISEASE **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HYPERTENS ON The law requires that the death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate had all director, page 1 Yes 1 Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No ၉ 3 DOA Division of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours are To the Funeral Dir Hospitel 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cont 727157 MARCH, 26, 2004 who completed cause of death (Item 23a) (Type, Print) 1 30. Name and address of perso 3100 LORD BALTIMORE DR HIIO, BALTIMORE, MD 21244 RAYNOLD DEPESTRE 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 3 1 2004 Registrar

			1- For State of Maryland / Departr Certifit	ment of Health and Meni icate of Death	tal Hygier	2001 00070
7	Physic /Medi Examii	ical	4a. Fecility Name (If not institution, give street and number) 4b.	, N	iarch 2	Oay Year 3. Time of Death 1308 P M
- 9	Funeral Director			Dunda1k Under 1 Year If Under 24 Hrs. 8, D onths Days Hours Min. (A) May	Pate of Birth Month, Day, Yea y 27 19	Baltimore 9. Birthplace (State or Foreign Country) New Jersy
	th the Maryland or 28a-f show	Director	10a. State 10b. County 10c. City, Town or Location	on Of, Zip Code	10g. (10d. Inside City Limits 1 ☐ Yes 2 ☐ No Sitizen of What Country?
36	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or terms 23a or 28a-f show other than "natural", or terms 23a or 28a-f show event, the Medical Evant, at route to notified at	by Funeral D	6707 Thruway 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 🖫 No 1 □ Yes 2 🖫 No	21222 Decedent of Hispanic Origin? (Specify No. s, specify Cuban, Mexican, Puerto Rican (res. 2⊠ No. Specify:	Yes or No- h, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	filed within 72 hou Hygiene. other than "natural ent, tre Medical E	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 NA Home Ma	s Usual Occupation of work done during most of working IOT use retired)	16b.	Kind of Business/Industry Own Home
Maryland 2121	be d fall	To Be	17. Father's Name (First, Middle, Last) Benjamin McConnell	18. Mother's Name (Firs Mary dress (Street and Number or Rural Rou	Ε.	Gavin
Baltimore, Ma	es 1 and 2 of Health a litem 27 is r other tre		Benjamin McConnell (Son) 6707 Th 20a. Méthod of Disposition 1 D Burial 2 Cremation 3 D Bennoval from State 20b. Place of Disposition cemetary, crematory	ruway Dundalk, Mar	cyland 2	
Balta	permit. Page Department Importent: If eny injury or once.		21. Signature of Funeral Service Licental W.	ne and Address of Facility Dabrowski-Chojnac D5 Dundalk Ave. Bal	cki Fune Ltimore.	ral Homes P.A.
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Arteriogal endicement of the condition resulting in death) Due to (or as a consequence of):			Interval Between
8/bU,	ate be executed thysician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that imitated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):			
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oras, r	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I. 23	3e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☑ Unknown
r	en: The law tificate has t	e Completed	25. Was case referred to medical		4a. Was an autopsy performed? Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No
VISION OF V	To the Hospitel or Attending Physicien: The law within 24 Hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certification: To B	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 3 Spirite 6 Could not be	DOA Other: 4 Nursing Home 5, 28c. Injury at Work? 1 Yes 2 No		
2	ospitel or At hours after of unerel Directly filled in by		4 Homicide determined 256. Place or injury: At nome, farm, street, la building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death accurately	cit	a to the course	·
•	To the H within 24 To the Fi complete	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
	\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Will CT. Luthe		1 aryland 21093
**	Sta Registra		31. Date filed (Month, Day, Year) MAR 3 1 2004 32. Registrar's Signature			1 21312

			For State Registrar	State of Maryland	/ Depa		ealth and	Mental Hygi	ene	04	09874
الحار	Physici /Medic		1. Decedent's Name (First, Middle, Last) M/CHAEL	ANTHONY	No			2. Date of Death Month MARCH		Year OEH	3. Time of Death
	Examin	ac a le	4a. Facility Name (If not institution, give s HARBOR HOSPITAL	cent and number)		4b. City, Town, or BALTIT	Location of Deal	h	4c. County o	of Death	
	Funeral Director		215-82-6257	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year) 1956	9. Birthpla Country Mary	
	Maryland a-fahow	ctor	Usual Residence of Decedent 10a. State Md. 10b. County n/a		Town or Lo					100	d. Inside City Limits 1 XYes 2 No
	with the	Director	10e. Street and Number 1628 Clarkson Str	cont		10f. Zip Code 2123	80	10	og. Citizen of W		y?
36	2 should be tiled within 72 hours atter death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f ahow aumatic avent. Its Medical Evantizer must be notified at	by Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates:	1		spanic Origin? (5 n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race	- Americar c, White, et	c.
Maryland 21215-0036	tiled within 72 hou Hygiene. ther then "nature int, the Medical E	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-40r 5+)	16a. Deced (Give life. L	lent's Usual Occupi kind of work done o DO NOT use retired	ation during most of wo	rking	6b. Kind of Bu		stry
land 2	uld be tiled Aental Hygi rked other tic avant, I	To Be C	17. Father's Name (First, Middle, Last) James J. Nolan Sr	•			18. Mother's Na Naomi	me (First, Middle, M	_{laiden Sumam} Fisher	9)	
Mary	id 2 sho Ith and N 27 Is ma (trauma		19a. Informant's Name/Relationship (Type Brian K. Nolan	(Brother)				ural Route Number, , Baltimo			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic as <u>once.</u>		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Ri 4 □ Donation 5 □ Other (Specify)	cen	netery, cren	sition (Name of natory or other place SS Cemete	ery 03/3		Baltimo	-	
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service License	Daniel K	22	Name and Address	y Polyn	iak Funera ve. Baltii	al Home	P.A.	230
	Physician		23a. Part . Enter the disease, or complication of the complete speck, or heart failure. List only on limit late Cause (Final disease or condition	SEPS15		er the mode of dyin	g, such as cardia	c or respiratory arre	st,	1	Approximate interval Between Donset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions.	Due to (or as a conseque		nsion S	econdary	to Sep	osis)		244~
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a consequence of): Due to (or as a consequence of):							
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Box 687	ertiticate ling phy e as the	Medic	IF FEMALE:				•				
P.O. Bo)	The law requires that the death certiticate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3	Ectopic pregnancy Other (specify)		· · · · · · · · · · · · · · · · · · ·	23d. Date Mor	of delivery	/ Day Year
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Division of Vital Records,	The law re cate has be page 2 sho	Completed by						24a. Was ar autopsy perform 1 Yes 2	ned?	rior to comp eath?	sy findings available pletion of cause of
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on of	ling Phy After this uneral d	 -	27. Manner of Death 1 Natural 5 Pending		28b. Time of Injury	28c. Injur Wor		28d. Describe ho			
)ivisio	I or Attending Physician: after death. Director: After this certifica I in by the funeral director. I	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str		163 2 110	28f. Location (Str City or Town	reet and Numbe , State)	er or Aural i	Route Number,
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2	edical Ce	29a. Certifier (Check only one) 1 Certifying Phys	icien: To the best of my know er: On the basis of examination and manner stated.	ledge, death on and/or in	n occurred at the tirvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and mai ite and place, a	nner as stat ind due to t	ted. he cause(s)
)	To the within To the complex	Me	29b. Signature and title of certifier	mD			17785	n	Od. Date signed	28,	2004
	9		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, /toSP17/	Print) CENT			nover	Street	1- MB 21225
e.V	St. Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	of Di	porket					
1	negist	rai	MAR 3 1 2004	/							

			1 ⊶ For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of I	Health and I	Mental Hyg	iene 2001	09875
Ī	Physici	an	Decedent's Name (First, Middle, La BERYL)	LOUISE	NASH	I	-	2. Date of Dea Month	Day Year	3. Time of Death
Maria Min	/Medio		4a. Facility Name (If not institution, gine MARINER HEALTH			4b. City, Town,	or Location of Death		26 2004 4c. County of Deat ANNE ARU	
	Funeral Director		219-10-9379	Sex 1 □ M 2 DATF 7. Ag	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days			Year) 9. Birt 1923 Pen	hplace (State or Foreign untry) Insylvania
	yland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	he Mar 8a-f s	ector	Maryland N/A		Baltimore	144 71 0 1			0.5	1 XYes 2 □ No
	3a or 2	Dir	3813 Roland Ave.	4)		10f. Zip Code	21211	- [0g. Citizen of What Co USA	untry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Erain at must be indiffied at ance.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 M If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036	filed within 72 hou Hygiene. ther than "natura ent, the Medical E	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		(Give life.	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	king	16b. Kind of Business/	Industry
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Mai	nd 2 sh alth and 27 is n r traun		19a. Informant's Name/Relationship Karen Sands (Dau	,		Roland A			; City or Town, State, 2 cyland 2121	
Baltimore,	iges 1 a nt of Hea : If Item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [Removal from State	20b. Place of Dispersion of Di	osition (Name of matory or other pla	100)	Date	20c. Location - City or	Town, State
altin	mit. Pa bartmer cortant injury		*4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Baltimore	Nationa Name and Addr		0-04 <u>P</u>	altimore, N	Maryland
ă	Depa Impo Impo Any it	8 0	Jan 6	Jayr	nh 3	204 Moun	OLYNIAK E tain Road	UNERAL HO	OME P.A. na, Marylar	nd 21122
**	Physician /Medical Examiner		23a Pārt 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. A	a consequence of):	er the mode of dyi	ng, such as cardiac	or respiratory arre	9st,	Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
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Divis	al or Att	Sertific	3 Suicide 6 Could not to determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Cartifying P. 2 Medical Exa	nysician: To the best minar: On the basis of and manner sta	examination and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	tuse(s) and manner as ate and place, and due	stated. to the cause(s)
)	To the vithing to the transfer comp.	M	29b. Signature and title of certifier	Kari IN	MD TERNAL	29c. Licens	. 125	1104	9d. Date signed (Month)	, Day, Year) 29, 2004
	X		30. Name and address of person who BALTIMORG	completed cause of d	eath (Item 23a) (Type,	Print) 47	10 PENI	VINGTO	NAVEN	JUA_
B	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	parks	V		VIV // I	

State of Maryland / Department of Health and Mental Hygiene 2004Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** San /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Mercy Medical Center **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** 1□M 2\ F Director 214-46-8381 63 Yrs June 16, 1940 Usual Residence of Decedent filed within 72 hours atter death with the Maryland 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
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Md. Veteran's Cemetery 3/30/04 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ottoe. Crownsville, Md. ^ 4 □ Donation 5 □ Other (Specify) McCully-Polyfiak Funeral Home, P.A 237 E. Patapsco Ave., Balto., Md. 21. Signature of Funeral Service Licensee Kevin E Ecker 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final bstructive Physician Years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Vital Records, P.O. Box 68760. attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chranic piratu 2 🗌 No 3 Probably 4 □Unknown , page 2 should Be Compieted 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner? 1 Yes 2 No Other: Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA Division of After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely the 29b. Signature and title of certified 29c. License number D3 Protect capse of death (Item 23a) (Type, Plint) 30. Name and address of person who com evins W fau 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

			1 - For State Registrar	State of Maryla		artment of He tificate of D			jiene 19. No. 200	4 09877
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	/Medic			Parson				Month 3	24 200	4 3:30P ^M
	Examir	er	4e. Facility Name (If not institution, give s 2150 W. Patapso			4b. City, Town, or to BAltimo			4c. County of D	eeth
	Eunaval		5. Social Security Number 6. Sex		rs. last birthday)		If Under 24 Hrs.	8. Date of Birth) 91	Birthplace (State or Foreign
	Funeral Director			M 2 X F 56	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day	1948	Country) MD
	P .		Usual Residence of Decedent	140-	0:- =				1010	
	aryla ehow	_	10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
	the M	ecto	MD 10e, Street and Number		Baltim				0g. Citizen of What	
	With Sa or	Funeral Director		30 ATTO		10f. Zip Code			_	Country?
	death	era	2150 W. Patapso	12. Was Decedent Ever in		Vas Decedent of His	panic Origin? (Sp	ecify Yes or No-		merican Indian,
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show important: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show injury or other traumatic event, the Medical Exatribational that indiffied at ance.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates:	1	f Yes, specify Cuban ☐ Yes 2∰No	, Mexican, Puerto Specify:	Rican, etc.)	Black, W Specify: B	
2-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupat	ion vina most of work	ina	16b. Kind of Busine	ss/Industry
21	within lene. then	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done du DO NOT use retired)		9	Federal	
2	Hygie Hygie other t	ပိ	12 17. Father's Name (First, Middle, Last)		Gov	't worke		(Fire Middle)	Social (Sec.
and	d be f	o Be	Thomas R. Vinso	on SR		1	Virgini			
Z Z	should and Men marke	2	19a. Informant's Name/Relationship (Typ		19b. Mailin				City or Town, State	a. Zip Code)
Š	and 2 salth a n 27 io		Norman James Ji	•					timore N	
ore,	es 1 an of Heal item 2 r other		20a. Method of Disposition		. Place of Dispo-	sition (Name of place)	, ,	Date	20c. Location - City	or Town, State
Ĕ	Pages ment of ant: If its ury or o		M Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	t. Zio	n Cem	3-30-	2004 B	alto. Co	o. MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Health important: If item 27 any injury or other tr once.		21. Signature of Funeral Service License E.N. Walker Jr			Name and Address Step Bro 300 Euta	of Facility S. Fune w Place	ral Se Balti	rv. P.A more MD	21217
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	e cause on each line.	th. Do not ente	or the mode of dying,	such as cardiac o	or respiratory arre	est,	Approximate
	Physician /Medical		tmmediate Cause (Finat disease or condition resulting in death)	LIVER		FILLERE				Onset and Death
Е	Examiner			Due to (or as a cons	equence of):	PANICRE	SAST ((ANCER	TO live	2 TUO MONTH.
	<i>&</i>	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):	PHOMIL	NI II C	7/104/1	LI CIVA	2 100 14010111
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	e exe ian ar urial-t	Ex	resulting in death) Last	Due to (or as a cons	equence of):					
68760,	ficate be executed physician and s the burial-transit	dical	d							
Ω̈́ ×	ding p	9	tF FEMALE:	On Name outcome of page						
P.O. Box	uires that the death certif signed by the attending d be detached for use a	Physician/M	in the past 12 months?	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of o Month	delivery Day Year
o.	the d y the iched	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9 Unknown	000001 5	Other (specify)				
σ,	s that ned b	by Pr	Part II. Other significant conditions con			derlying cause given	in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds	quire on sig uld b	ed b	PULMONARY	FMBOUS	M			1 ☐ Ye	s 2 🗆 No 3 🗔	Probably 4 X Unknown
900	iaw requir as been s 2 should	Completed						24a. Was ar	n 24b. Were	autopsy findings available
m m	The lav ate has page 2	mo:						autops perform 1 Yes 2	ned? death'	o completion of cause of ? es 2 No
/ita	ilcian: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Death			
£	Physic this co	2	1 ☐ Yes ?X No		☐ ER/Outpatient		4 Nursing nor		nce 6 Other (Sp	pecify)
N O	ding P. After funera	lon:	27. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of tnjury	28c. Injury a Work?		28d. Describe ho	w injury occurred	
Division of Vital Records,	I or Attend after death Director: A I in by the fi	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At	home farm stre		s 2 🗆 No	284 Location /Str	mat and Alumbar as	Rural Route Number.
<u>></u>	after Direction of the control of th	Certification:	4 Homicide determined	building, etc. (Spec	cify)	et, lactory, office	'	City or Town	. State)	Hurai Houte Number,
	To the Hospital or Attending Physicien: The law requires that the death certif within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier (Check only one) (Check only one) (Check only one)	ician: To the best of my k	nowledge, death nation and/or inv	occurred at the time, estigation, in my opin	, date and place, a nion, death occurre	and due to the ca	use(s) and manner atte and place, and de	as stated. ue to the cause(s)
	o the or the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License r			d. Date signed (Mo	
)	じょとし		> PLEDATCIS 1	W)		:047	934		ARCH 20	
	m		30. Name and address of person who cor		em 23a) (Type F	Print),		1,1	4-74	(0,000)
			Prostuis N	y ME	RCY MI		RUTET			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2004	32. Registrar's Sig	nature					

1 - For State Registrar		of Maryland / Dep <i>Ce</i>	artment of F			Reg. N2 0	04 09878
1. Decedent's Name (First, Physician Janice	Middle, Last)	Penn			2. Date of De Month March	24, Day 2004	3. Time of Death 10:12 P M
/Medical Examiner 4a. Facility Name (If not instance) 4933 Bryant			4b. City, Town, o Wald	Location of Deat		4c. Count	
Funeral Director 5. Social Security Number 245-52-9789 Usual Residence of Decade	6. Sex 1 ☐ M 2 ☒ F	7. Age (In yrs. last birthday, 66Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th Year 937	9. Birthplace (State or Foreign County) North Carolina
0		10c. City, Town or L Waldori					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
10e. Street and Number 4933 Bryan	town Rd.		10f. Zip Code 20	501		10g. Citizen of US	·
Maryland CC Maryland 10a. State ment the Maryland 10a. Street and Number 4933 Bryan 10a. Street and Number 4933 Bryan 11a. Marital Istatus 11a. Marital Istatus 11a. Mover Mamied 12a. Street and Number 4933 Bryan 11a. Marital Istatus 11a. Mover Mamied 12a. Street and Number 4933 Bryan 11b. Decompleted px Mills 11b. Decompleted 11b. Decompleted 12a. Street and Number 11b. Decompleted 11b. Decompl	Married 1 Yes	2∰ No ive	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	Ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rad Bla Specif	ce-American Indian, ick, White, etc. y: White
Vand 21215-00 buld be filed within 72 buld be filed wi	cedent's Education highest grade completed	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired President	during most of wo l)	rking		tric Utility
Dudy by the service of the service o					me (First, Middle, es Copel	Maiden Sumar	
19a. Informant's Name/Rel William D. P 20a. Method of Disposition 1 Burial 2 Crem.	enn/husband ation 3 □Removal from	4933 20b. Place of Dispo	matory or other place	vn Rd., Mar	Maldorf,	MD 206	
A Donation 5 Other Transfer of A Donation 5 Other Transfer of		2		s of Facility Br	insfield	-Echols	F.H., P.A.
Physician /Medical Examiner Popularian Medical Examiner	a	caused the death. Do not en each line. (or as a consequence of): (or as a consequence of):	CA M	CEA	2 or respiratory and	Test,	Approximate Interval Between Onset and Death
The law requires that the death certific the law requires that the death certific the law requires that the death certific the law requires that the death certific as a specific to the law requires that the death certific as a specific to the law requirements of the law	1 Live	nant at time of death 5	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
w requires that we define that the designed by the design of the design	nditions contributing to c	leath but not resulting in the u	nderlying cause give	on in Part I.		obacco use cont	ribute to the cause of death? 3 ☐ Probably 4 💆 Unknown
Ysician: The law require sis is conflicted has been a director, page 2 should examined.					1 ☐ Yes	rmed?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to m exeminer?	Hospital:	Inpatient 2 ER/Outpatier	t 3 DOA Othe		ome 5 A esid		er (Specify)
27. Manner of Death	vestigation ould not be	of Injury and Injury 28b. Time o Injury and Injury - At home, farm, string, etc. (Specify)	M 1 🗆 Y		28d. Describe h	ow injury occurr	
2 5 2 2 0 O	tifying Physicien: To the	a best of my knowledge, deat	n occurred at the tim	e, date and place	and due to the	Pause(s) and ma	inner as stated.
A continuity of the control of the c	and mar	easis of examination and/or in iner stated.	vestigation, in my op				and due to the cause(s) d (Month, Day, Year)
1 Koust	2 H/t	Talle	020	F.35)		3/25	704
30. Name and address of po	0 0	se of death (Item 23a) (Type,	03	Plas	a re	1 2	0646
State 31. Date filed (Month, Day, Registrar		Registrar's Signature	Sporks	1			

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment ertificate					giene Reg. No2	004	09879
	Dhusisi		Decedent's Name (First, Middle	, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medio		Carrol1		Jacob			Pod1	Les	March	29	2004	4:00 p ^M
4	Examir		4a. Facility Name (If not institution			4b. City, T			of Death		4c. C	ounty of Death	
			Johns Hopkins							,		NA	
	Funeral Director		5. Social Security Number 220–03–2638	6. Sex 7. Ag	ge (In yrs. last birthday 82 Yrs.	Months	Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da) Dec. 7	1921		place (State or Foreign ntry) yland
	pur *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation							10d. Inside City Limits
	sho	ō	Maryland Balti	more	Dundal								1 ☐ Yes 2X No
	28a-1	ect	10e. Street and Number			10f. Zip (`ode			· · ·	10a Citiza	n of What Cou	
	with Baor	Funeral Director	7858 St' Greg	ory Drive			222				-	J.S.A.	
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13			spanic Ori	igin? (Sp	ecify Yes or No-		. Race - Ameri	can Indian,
	riter o	들	1 ☐ Never Married 2 ☑ Marri	Armed Forces'	No 1942	If Yes, specif	y Cubai	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
93	urs a	ξ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1945	1 ☐ Yes 2	⅓ No	Specify:			Si	pecify: Wh	ite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show te Madical Exertirer mast be notified at	Completed	15. Decedent (Specify only highes	's Education	16a. Dec	edent's Usual	Occupa	ition	t of work	ina	16b. Kind	of Business/In	dustry
7	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or	5+)	e kind of work DO NOT use	retired,	uning mos	I OI WOIK	mg			
7	ad wi	Son	8	NA	Pro	prieto	r				Groc	ery St	ore
nd	be fill tal Hy d oth	Be	17. Father's Name (First, Middle, I	Last)						e (First, Middle,	Maiden Su		
yla	Men Men arke	ို	Jacob		Podle				ther				elski
<u>Ta</u>	12 should be filed within hand Mental Hygiene. 7 is marked other than "reumatic event, Ite Ma	1	19a. Informant's Name/Relationsh							al Route Numbe			
	1 and Health tem 27 other tr		Anna Podles	(Wife)						Dunda1			
9	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 反 Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Disp cemetery, cre		er place		Apri		20c. Loca	tion - City or To	own, State
Ē	Pa tmen tant: jury		*4 □Donation 5 □ Other (Sp		Holy R				2,20			1k, Ma	,
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Macale Exercities inside a notified at once.		21. Signature of Funefral Service I	d. Tom	acki.	W. Dab	Addres YOWS	s of Facilit SKi−C alk Δ	hojn	acki Fu Baltimo	neral	Homes	P.A.
3760,	zate be executed WAMAN Amount of the burial-transit the burial-transit the burial-transit was a second of the burial-transit than a second of the burial-transit was a second of the burial-tra	licai Examiner	23a. Part 1. Enfor the disease, or shock, of heart failure. List of the shock of heart failure. List of the shock of heart failure. List of disease or condition resulting in death) Sequentially is conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	itheros.	clerot	re o si	He	art	Dise	ase		Interval Between Onset and Death
P.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death 3	□Ectopic pred □ Other (sped					230	d. Date of delive Month	eny Day Year
	ires that signed b	by	Part II. Other significant conditio				ise give	n in Part I.			_	_	ne cause of death?
or C	w requir been si should	sted	DAT	6structus	7 (70-00110)	PU			7 7	es 2 X		ably 4 Unknown
Vital Records,	hysician: The law his certificate has t I director, page 2 s	Completed	napeles	rellities						24a. Was a autop: perfor	SV .	prior to con death?	psy findings available mpletion of cause of 2 No
ita	ian: artifica ctor,	Be (25. Was case referred to medical examiner?					26. Place	of Death	(Check only or			
of V	hysic his ce I dire	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati			-	4 🗀 NU	rsing Ho	me 5 🗆 Resid	ence 6	Other (Specify	y)
ion o	fe		27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investig	ation	ury 28b. Time o ly Year) Injury	of 286	Mork Work 1 □ Y	at ? ′es 2 □ i		28d. Describe h	ow injury o	ccurred	
Division	al or Atter after de l Directo d in by th	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of in	jury - At home, farm, si c. <i>(Specify)</i>	reet, factory,	office			28f. Location (S City or Tow		lumber or Rura	l Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1 Certifying 2 Medical B	Physician: To the best examiner: On the basis of and manner st	if examination and/or ii	th occurred at rvestigation, in	the time	e, date an inion, dea	d place, th occurr	and due to the c	ause(s) an ate and pla	d manner as si ace, and due to	ated. the cause(s)
	Fo th within Fo th	Me	29b. Signature and title of continue	5	/	1		number		2	9d. Date s	igned (Month,	Day, Year)
è	->-0) / n	m -15	_	0	01	1150)		Marc	h 30,20	04
	5.41		30. Name and address of person v	who completed cause of	death (Item 23a) (Type								
	01				South Ellw		enus	R ₂ 1	timo	ro Mar	vland	21224	
	Sta	te	Malito Torres 31. Date filed (Month, Day, Year)		ar's Signature			_ nal	ن بسر	re, rat	удана	4144	
	Registr		MAD 3 1 200	4 Bank	~ B	book.							

			1 - For State Registrar	State of Marylan	·	ent of Health and ate of Death		ene g. No. 2004	09880
	Physici /Medi	cal	1. Decedent's Name (First, Middle, La EDWARD	ROSE	-		2. Date of Death Month MARCH	Day Year 2004	3. Time of Death
de la companya de la	Examir Funeral Director	ner	4a. Facility Name (If not institution, given the second of	urs Hospi	tal ?	ty Town, or Location of Dea Higher Year If Under 24 Hr. Is Days Hours Min	S. B. Date of Birth	4c. County of Deeth Year) 9. Birthp	lace (State or Foreign
	Maryland n-f show	tor	10a. State 10b. County	10c. City	y, Town or Location	re		1	0d. Inside City Limits 1⊈Yes 2 □ No
	be filed within 72 hours after death with the Maryland stal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, If a Medical Exercitive most be multified at	Funeral Director	10e. Street and Number 6/9 N - Calh 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Ye} \) No	<u> </u>	Zip Code 21217 Dedent of Hispanic Origin? (2) Decrify Cuban, Mexican, Pue		g. Citizen of What Coun 14. Race - Americ Black, White,	en Indian,
215-0036	72 hours at "natural", or	Completed by I	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's E (Specify only highest gr.	If Yes, Give Year or Dates:	16a. Decedent's U	work done during most of wo	orking 1	Specify: B/C	2CK dustry
21	filed within I Hygiene. other then "	Be Comp	Elementari /Secondary (0-12) 17. Father's Name (First, Middle, Last	College (1-4or 5+)	Labo	rer	me (First, Middle, M	BNSHU	tron
Maryland	s 1 and 2 should be t Health and Mental Item 27 is marked o other traumatic eve	ToB	19a. Informant's Name/Relationship	YOSU Type, Print) G	19b. Mailing Addre	ss (Street and Number or R	100 / 1	City or Town, State, Zip	Code)
	0 0 = =	1	20a. Method of Disposition	JRemoval from State	lace of Disposition (A emetery, crematory)	Jame of James (Date 2	0c. Location - City or To	Wn, State
Baltimore	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service) Lice	W P NI	y Merro	and Address of Racility	41/04 F	Saltimore	CAD 1000
SPINE -	Priysician /Medical Examiner		23a. Pert1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line. a. ACV TE MY Due to (or as a consequence)	OCARDI	ode of dying, such as cardia	,	st,	Approximate Interval Between Onset and Death
8760,	4	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence of Due to (or a consequence					
P.O. Box 68	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3 Ectopic			23d. Date of delive Month	ry Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions of	contributing to death but not resu	alting in the underlying	g cause given in Part I.		cco use contribute to th	e cause of death?
Vital Records,		Completed					24a. Was an autopsy perform	prior to con death?	osy findings available inpletion of cause of
Viita	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examinat?	Hospital:		Othor	ath (Check only one)		
of	ding Physic. th. After this funeral di	 -	1 Pes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 2 28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	dome 5 Residen 28d. Describe how	ce 6 Other (Specify rinjury occurred	')
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific. completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		me, farm, street, fact	ory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
	Hospi 24 hou Funer felly fill	edical	29a. Certifier 1 ☐ Certifying Pt (Check only one) 1 ☐ Certifying Pt 2 ☐ Medical Examone)	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, death occurre tion and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cau urred at the time, dat	ise(s) and manner as sta e and place, and due to	ated. the cause(s)
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Med	29b. Signature and title of certifier	Mary MD	2	9c. License number	290	d. Date signed (Month, D	Day, Year)
	\bigcap		30. Name and address of person the	completed cause of death (Item	23a) (Type, Print)	D31993 W BALTIM	ORE ST	- BALTIMO	21223
8	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2004	32. Registrar's Signat	turo -	Me 1	- 1	.,-,,,,,	

Dwight C. Robinson

State of Maryland / Department of Health and Mental Hygiene

Reg. No. 2	n	n	1.	0	0	8	0
Reg. No.	V	U	help	U)	O	O

		1 - State Registrar		Ce	rtificate of	Death	Red	g. No. ZUUL	0988
		1. Decedent's Name (First, Middle, L	ast)			2. Date of Death	. Date of Death 3. Time of Deat		
Physicia		Dwight	C.	Robins	on		Month March 2	Day Year	1055 a ^M
/Medica Examine		4a. Fecility Name (If not institution, g 103 N. Milton	ve street and number)	KODIIIS	4b. City, Town, o	or Location of Death		4c. County of Death	
					Baltimo			NA	
Funeral Director		5. Social Security Number 6. 217–60–4225	Sex 7. Age 1 7. Age 50	(In yrs. last birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) 2-14-54	Year) Cou	place (State or Foreigi intry)
D.		Usual Residence of Decedent							
uylar show	_	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
e Ma	cto	Md. NA		Balti	more				1 XYes 2 No
or 26	Director	10e. Street and Number			10f. Zip Code	-	100	g. Citizen of What Cou	intry?
23a	E	103 N. Milton A	æ.		2122	4		USA	
or deg	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
urs a	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:	0	1 □ Yes 2√2 No	Specify:	,	Canaita	ack
n 72 h	Completed	15. Decedent's l (Specify only highest g		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	sing 16	6b. Kind of Business/Ir	ndustry
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is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Rur	al Route Number, C	City or Town, State, Zi,	code)
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ortan injur		21. Signature of Funeral Service Lice	-		2. Name and Addre				
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ysician: Th	ne L	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)	(10)	20110
% ≅ ö	0	1 XYes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Ho	me 5 Residence	e 6 Dother (Specify	at scene
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral managements.	Certification:	3 Suicide 6 Could not to determined	28e. Place of Injury building, etc.	y - At home, farm, stre (Specify)	eet, factory, office		28f. Location (Stree City or Town, S	it and Number or Rura State)	I Route Number,
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To the vithin o the omple	_	29b. Signature and title of oprtifier	and married state		29c. License	number	29d.	Date signed (Month, I	Day, Year)
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'n	ŀ	30. Name and address of erson who	completed cause of dea	ith (Item 23a) (Type I	Print)				
J		JACK M T.	TUS MID	,, (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		nn Street	, Baltimo	ore, Maryla	and 21201
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #58106 tate of Maryland 30 experiment of Health and Mental Hygiene 2004 09882 For E State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year ROTHBARD 03 04 4c. County of Death 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death ROSe da le If Under 1 Year | If Under 24 Hrs. | Hours | Min. Franklin Square Hospita1 Center Itimore 8. Date of Birth (Month, Dey, Yeer) JUNE 27, 1925 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Sof 335-164/2940-6. Sex 1**∑** M 2□ F Months 113-16-2340 78 NY Usual Residence of Decedent 10b. County FFLD 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No FELD CTSTRATFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 235 HENRY AVENUE #11C 06614 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC U.S. POSTAL SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MORRIS ROTHBARD FRIEDA SCHECHTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID ROTHBARD / SON 621 HARVEST COURT - BEL AIR, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) EINTRACHT CEMETERY 3/30/2004 FAIRFIELD, CT 21. Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days Se p613

Due to (or as a consequence of). rneu monia Sequentially list conditions, it any, leading to influentiate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Dua to (or as a consequence of) hironic fumphocytic Leuhemia Due to (or as a consequente of): IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation Chronic 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Renal Failure Disease 24a. Was an artera autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 🔼 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Maryland 21215-0036

Baltimore,

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of tertifier 29d. Date signed (Month, Day, Year) 29c. License number D-51555 03-27-2004

Baltimore, Md. 21237

State Registrar

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MAR 3 1 2004

Sein Aung

30. Name and add of person

31. Date filed (Month, Day, Year)

Franklin Square Drive 32. Registrar's Signature Anoth!

who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 4:05AM Physician Alan J. Steininger 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE T. AGNE'S 1-EALTH If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug 1, 1916 Birthplece (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** Days 1 X M 2 □ F 87 Indiana Director 577-12-1343 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County ir then "natural", or itams 23e or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Baltimore Catonsville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 719 Maiden Choice Lane BR509 21228 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give Year or Dates: 143-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: white 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) congressional records clerk U.S. Govt permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other eny injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Darius Ambrose Steininger Elma Arvilla Wetherbee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Steininger/son 107 Muirfield Drive Blue Bell, PA 19422 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wards State Anatomy Board 655 W. Baltimore Street nan Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician dings /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician the IF FEMALE esn 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed , page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 WUnknown DIABETES Be Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed ATRIAL FIBRILLATION 1 Yes 2 No certificate 1 Yes 2 No Division of Vital Physician: After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospital or Attending 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier -17598 03-25-2004 M.D BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARE 900 CATON AVE. UMESH INAMPUDI ST. AGNIE'S HEALTH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 2004 Registrar

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Physician /Medica Examine Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marylan

nd / Department of Health and Mental	Hygiene	2	í
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Funeral Doi3 09/22/1939 **Director** Baltimore, Maryland 21215-0036 3/14/64 2/24 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Trygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, If a Medical Examiner must be notified at once. Gordon C. Shapiro

Physician /Medical Examiner attending physician and for use as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death. To tha Funeral Diractor: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached f

	1 - For State Registrer		(Certificate of Death					Reg. No. 2004 09884				
	1. Decedent's Name (First, Middle, La	st)		2. Date of De Month						ау	Year	3. Time	of Death
0	Gordon C. Sha	piro							14	7 (04	9:25	2 PM
r	4a. Fecility Name (If not institution, give	e street and number)		4b. City,	Town, or I	Location of D	Death		4	c. County	of Death		
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Directo	10e. Street and Number			10f. Zip	Code				10a. C	itizen of V	What Cou	ntry?	
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era	11. Marital Status	12. Was Decedent Eve	13. Was Deced			? (Specify	Yes or No)-	14. Rac	e - Americ	can Indian,		
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ge	17. Father's Name (First, Middle, Last						lother's Name (First, Middle, Maiden Surmame)						
0	Daniel Shapi		rothy										
	19a. Informant's Name/Relationship (Wilma Shapiro/			Mailing Address							State, Zip 218		
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Š	29a. Certifier 1 Certifying P	hysician: To the best of	my knowledge	death occurred	at the time	a date and	nlace and	due to the	Cause/	s) and ma	anner as s	stated.	
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	30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type, Print)	,	_		Λ -			1)	0	
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j 25	Director		162-22-8132	X M 2□F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day Mar 12;	1924	Penr	nsylvania
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,8760,	death certificate be executed e attending physician and of for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c									i	
P.O. Box 6	at the death certific. by the attending plached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3 🗌	Ectopic pre Other (spe						Date of delive	ery Day Year
	The law requires that the tee has been signed by the sage 2 should be detache	by	Part II. Other significant conditions of	intributing to death bu	t not resu	lting in the un	derlying ca	use give	n in Part I.					he cause of death?
Vital Records,		Completed									24a. Was a autops perform	ned?	D. Were auto prior to coo death? 1 Yes	psy findings available mpletion of cause of 2 No
ō	ling Phys After this tuneral dii	tion: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1⊠Inpatier 28a. Date of Injur (Month, Day		ER/Outpatient 28b. Time of Injury		Other	4 Nurs	sing Hon 2	(Check only on ne 5 Reside 8d. Describe ho	ence 6 🗆 C		v)
Division	tel or Attendi rs after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc	ry - At hor (Specify,	me, farm, stre	et, factory,	office		2	8f. Location (St. City or Town	reet and Nu , State)	mber or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in the compl	Medical	one)	rsician: To the best of iner: On the basis of and manner state	examınatı	vledge, death ion and/or inv	occurred a estigation,	t the time in my opi	o, date and nion, death	place, a occurre	nd due to the ca d at the time, da	ause(s) and ate and place	manner as st	ated. the cause(s)
)	or noo	2	29b. Signature and title of certifier) MO				License				9d. Date sign	red (Month, a	Dey, Year)
				SOUTH GRE	ENE S	FREET				1.0	21201			,
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2004	32. Registra	r's Signati	Ure A	par	2						

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of M		d / Depa		Health and	-		200	L 19886
	100	- 2	Decedent's Name (First, Middle, Last						2. Date of I			3. Time of Death
	Physici /Medi		JOSEPH	MYER		SMO	OT			H 28 2		15:30 M
	Examir	ier	4a. Facility Name (If not institution, give UPPER CHESAPEAKE	MEDICAL C			BEI	or Location of Dea		H	County of Dea	COUNTY
	Funeral Director		210-44-0313	x 7. Ag X M 2□ F	6 (In yrs. 56	last birthday) Yrs.	If Under 1 Yea Months Day					rthplace (State or Foreign ountry) ryland
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo						10d. Inside City Limits 1 X Yes 2 ☐ No
	with the 3a or 28a-	I Director	10e. Street and Number 2609 Northshire	Drive	1		10f. Zip Code	1230		10g. Citi	zen of What C	•
336	filed within 72 hours after death with the Maryland Hygiene. ther then "naturs!", or Items 23s or 28s-f show int, the Medicel Examinal must be notified	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🐼 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 [X] Yes 2 [] I If Yes, Give Year or Dates:			Vas Decedent of Yes, specify Cu	Hispanic Origin? Iban, Mexican, Pue o Specify:	(Specify Yes or I erto Rican, etc.)		14. Race - Ame Black, White Specify: W.	
307m	within 72 hou ene. then "natura ne Medical E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5	i+)	(Give		upation e during most of w red)	rorking		nd of Business	
7.5 Jund 21	a la b	Be	8 17. Father's Name (First, Middle, Last) Hiram J.	Smoot Sr.		Truck	Driver	18. Mother's N	ame (First, Midd	le, Maiden	sumame) Cook	eight
/ Maryland	d 2 should be filed v in and Mental Hygie 7 ie merked other traumatic event, tr	ပ္	19a. Informant's Name/Relationship (T) Heather Hall		r)			et and Number or F Street, A	Rural Route Num	ber, City or	r Town, State,	Zip Code)
~			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F			And the Control of the Control of	sition (Name of patory or other p		Date	-	cation - City or	Town, State
3/28/04 Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other ance.		*4 Donation 5 Other (Specify, 21. Signature of Feneral Service Licens		Mar			s Cem.04,			nsville	
W B	a d i i d		gara Selection diseases or come	tugge	M	Do not onto	130	Tiy-Polyr E. Fort	liak run Ave. Bal	eral timor	e, Md.	21230
•	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only d Innediate Cause (Final disease or condition resulting in death)	ne cause on each lie RESPLE Due to (or as	RATI	RY		LURE	ac or respiratory	arrest,		Approximate Interval Between Onset and Death 2 DAY
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. CHRON Due to (or as	C	OBSTR	uctive	= PULMO	NARY	D/5	EKSE.	
735	ite be executed ysician and ne burial-transit	Icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	uence of):						
84 414	that the death certificate be executed of by the attending physician and detached for use as the burial-transit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregnan Other (specify)	су		2	3d. Date of dei	livery Day Year
M ds, P	uires that the signed by Id be detac	d by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resu	ulting in the un	derlying cause g	jiven in Part I.		tobacco us		o the cause of death?
e p h	The law requires that the tte has been signed by the bage 2 should be detache	ompiete	ATRIAL FIBR	ILLATIO	Ν				per	opsy formed?	prior to death?	utopsy findings available completion of cause of
7 S S	(0	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only	2 No	1 1 103	2 20 140
175	Phys this ral dii	၉	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	lospital: 1 / Inpatie 28a. Date of Inju. (Month, Date		ER/Outpatient 28b. Time of Injury	3□ DOA O		Home 5 Res			cify)
ost,	ttenk death tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injude	ury - At ho	me, farm, stre	M 1 (Yes 2 No	28f. Location City or T	(Street and	Number or Ru	ural Route Number,
()	Hospitel or At 124 hours after 6 Funerel Directels in by filled in by	edical Ce	(Check only 2 Madicel Exam)	sician: To the best oner: On the basis of	examinat	wledge, death	occurred at the	time, date and place	ee, and due to the	e cause(s) a	and manner as	stated.
0 /	To the Hos within 24 h To the Fur completely	Med	one) 29b. Signature and title of certifier	and manner sta	ited.			nse number			signed (Monti	
	¥ ₹ ₹ 8		► MABaya	ula	Mi	>	DI	5747		MARC	429	2004
	101		30. Name and address of person, o co	3 HYANGA	尺	INO	ety A	NENUE	BEL	175	11/2	21014
	Sta Registr		31. Date filed (Month, Day, Year) MAD 3 1 2004	32. Registra	ar's Signat	B A	souls					,

			1_ For State	State of Mary	land / Dep		lealth and	Mental Hyg	giene		0.0	_
			Registrar		Ce	rtificate of	Death		leg. No. 2 (104	09	88
	Physic	ian	1. Decedent's Name (First, Middle, Las Elizabeth Gonzales	*				2. Date of Dea Month	Day 28	2004	3. Time of I	
1	/Medi Examir		4a. Fecility Name (If not institution, give			4b. City. Town o	or Location of Deat	March	4c. County		7:30	Рм
	LAdiiii	iei	College Manor Assi			Luther			Baltimore			
	Funeral		5. Social Security Number 6. Se	3.7	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year)	9. Birthpla	ce (State or	r Foreign
н	Director		218-34-0121 1	⊒M 2 X 0F 9	8 Yrs.	monard Days	7,00,0	8. Date of Birth (Month, Day April 1	2, 1905	New	"York	
	ehow		10a. State 10b. County	100	c. City, Town or Lo	ocation				100	d. Inside City	y Limits
	Man B-f eh	tor	Maryland Baltimon	re	Luthervi	.11e					1 🗆 Yes	2 ∑ No
	or 28	Olrec	10e. Street and Number			10f. Zip Code		1	log. Citizen of V	Vhat Country	y?	
	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow dical Examiner must be institled at	Funeral Director	300 W. Seminary Av			21093			United			
10	tter de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 X No	in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race Blac	Americar k, White, et	ı Indian, c.	
93	al', or	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		1X Yes 2□ No	Specify: S	panish	Specify	whit	e	
5-0		Completed	15. Decedent's Ed (Specify only highest grad	ication le completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rkina	16b. Kind of Bu	siness/Indu	stry	
121	withir Bne. than	Jumo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retired egistered	_		nursin	C.		
d 2	filed Hygi thar	Be Co	17. Father's Name (First, Middle, Last)		<u> </u>	egistered		me (First, Middle, I		<u> </u>		
ılan	thould be id Mental marked o	ToB	William Gonzales				Tda Anr	na Frey				
Maryland 21215-0036	2 she and ts m		19a. Informant's Name/Relationship (T			ng Address (Street					ode)	
	1 and 1 ealth 1 m 27 1 har tr		Margaret S. Bryant 20a. Method of Disposition			ake Robir		Cockeysvi				
Baltimore,	Pages nent of h ant: If its arry or of		1 ☐ Burial 2 X Cremation 3 ☐ I	tomovan nom State		sition (Name of natory or other plac	1		20c. Location - (
ij	permit. Pages Department of Important: If I any injury or once.		 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens 	- 1	reenmoui	nt cremat	ory Mar.	30, 2004	Baltin	nore,	Maryl	.and
B	Depa Depa Impo any ii		John O. Mite	Rell X		Name and Address Mitche 6500 \	ell-Wiede Vork Rd	efeld Fun Baltim	eral Ho	me, I	nc. 12	
			23a. art1. Enter the disease, or comp shock, or heart failure. List only of	ications that caused the cone cause on each line.	death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	A	pproximate nterval Betwe	veen
	Physician		Immediate Cause (Final disease or condition	Alsee	meis	Disease					nset and De	
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					0	gears	7 -
22		-	Sequentially list conditions,	o. Oua to (or se a con	Europe of :							
	od ansit	Examiner	Sequentially list conditions, fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,							
Ö,	eath certificate be executed attending physician and for use as the burial-transit		resulting in death) Last	Due to (or as a con	sequence of):							
	e X e	lical		d								
89 x	ding p	Physiclan/Med	IF FEMALE:	3c. If yes, outcome of pre	100 200V				1			
Вох	atten atten I for u	clan	in the past 12 months?	1 Live birth 2 ☐ F	etal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of delivery th Da	іу Үө	ear .
o.	that the dead by the detached	hysi	1 □ Yes 2 ☑No 9 □ Unknown	9□ Unknown		, отто (оросту)						
S, P	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	by P	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contril	bute to the o	ause of dea	ath?
ord	w requir been si should	ted	have		 			1 🗆 Ye	s 2⊡No 3	3 ☐ Probabi	y 4 □Un	iknown
Records,	he law has b	Completed						24a. Was ar autopsy	y / pr	or to compl	findings av	vailable use of
								perform 1 Yes 2		ath? ☐Yes 2[] No	
Vital		o Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:	ΠΕD/0.1-11-1	Othe		ff Check only one		_		
of	g Phye erthis eral di	F +	27. Mann- Death	1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of	28c. Injury Work	4 *Trursing H	ome 5 Reside				
<u>jo</u>	Attanding Isr death. ractor: After by the funer	atlo	1 ✓ Natural 5 ☐ Pending investigation	(Month, Day Year	r) Injury		res 2 □No					
Division	l or Attane after death Diractor: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Spi	t home, farm, streecify)	et, factory, office		28f. Location (Str City or Town,	eet and Number State)	or Rural Ro	oute Numbe	эг,
	Hospital 24 hours a Funaral D tely filled i		29a. Certifier 1 Certifying Phys	ticing. To the heat of mu	kaandadaa daask							
	To the Hospital or A within 24 hours after To the Funaral Dira completely filled in b	edical	(Check unly 2 Medical Exami	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, death lination and/or inv	estigation, in my op	e, date and place, inion, death occur	and due to the ca red at the time, da	use(s) and man- ite and place, an	ner as state id due to the	d. a cause(s)	
	To the within 2 To the complet		29b. Signature and title of certifier			29c. License	number	29	d. Date signed	(Month, Dey	Year)	
)			1 Bune	Lase	Much	(MO I	12-4/2	/	3/29/0	24		
	3		30. Name and address of person who co	mpleted cause of death (Item 23a) (Type.)	rint)		/	1 1	0 1-		
	Sto		31. Date filed (Month, Day, Year)	32. Registrar's Signature	21/V	U55T	RD /	OWSON	, My	212	04	
tra_	Sta Registra		MAD 9 1 2004	Frances	& So	a Kal						

		1 - For State Registrar AMEND ITEM #6	PER FH (3830 4/09	7 Depa 7/04 @g	rtificate	e of L	eaith and D <i>eath</i>	d Mental Hy	giene 2	2004	0988	
Physic		DAPHNE P. SMI							2. Date of De Month MARCH 2	Day	Year	3. Time of Death	
/Medi Examir		4a. Fecility Name (If not institution, give MILLENNIUM @ FRANKLI)		ber)		4b. City,		Location of De			inty of Death	12.13411	
Funeral Director		5. Social Security Number 6. Security Number 1 C		. Age (In yrs. ia 48	Van	If Under Months	1 Year Days	If Under 24 H		y, Year)	9. Birthp	olace (State or Foreign ntry) 1D	
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD NA		10c. City,	Town or Lo						0d. Inside City Limits		
th with the 23a or 28	Funeral Director	10e. Street and Number 736 N. SARATOG/	A STREET			10f. Zip	Code 212	O1		10g. Citizen	g. Citizen of What Country? USA		
ore, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygione item 27 is marked other than "natural", or itams 23s or 28s-f. show other traumatic event, the Medical Examinar must be notified at			Armed Forces? 1 ☐ Yes 2 🔼 No		Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica Yes 2 No Specify:			(Specify Yes or No erto Rican, etc.)	cify Yes or No- lican, etc.) 14. Race - A Black, W Specify:		etc. FRICAN		
		15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12) 11th	cation e completed) College (1-4	or 5+)	life. L	lent's Usua kind of wor DO NOT us REATIO	k done du e retired)	iring most of w	vorking	16b. Kind of Business/Industry BALTIMORE CITY			
Maryialia /	To Be Completed	17. Father's Name (First, Middle, Last) THEORDORE	SMITH						ame (First, Middle)	Maiden Sum TH	ame)		
ore, with		19a. Informant's Name/Relationship (Type, Print) 19b. Mai PAULETTE D. CARTER (AUNT) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State					MICH	AEL LAN	Rural Route Numb E APT.103 Date	RANDALI	r, City or Town, State, Zip Code) RANDALLSTOWN, MD 21133 20c. Location - City or Town, State		
Dattimore, permit. Pages 1 ar Department of Hea Important: If item any injury or other		1 Ma Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		110	ZION C	•	Y.	APRI	L 1, 2004 WYLIE FUNER		OWNE, MI PA)	
Physician /Medical Examiner	- A4		ACQ U	n iine.	Do not ente	r the mode	of dying,	such as cardi	ET BALTIMO ac or respiratory at	rest,		Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	Due to (or	as a conseque								,	
that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		1 2 ☐ Fetal d t at time of dea	eath 3 🗌	Ectopic pre Other (spe				1	Pate of deliver	y Day Year	
he law requires that e has been signed b ige 2 should be deta	by	Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the			
	e Completed	25. Was case referred to medical								med? 2 X No	prior to com death?	sy findings available pletion of cause of	
\ 5	To B	examiner? 1 Yes 2 No H 27. Manner of Death 1 Agatural 5 Pending investigation	ospital: 1 Inpa 28a. Date of li (Month, l		P/Outpatient 8b. Time of Injury		Other: c. Injury a Work?	4 Jursing	Home 5 Resid	ence 6 🗆 O			
spital or Atten ours after deatl neral Diractor: filled in by the	Certification:	3 Suicide 6 Could not be determined		Injury - At hom etc. (Specify)					28f. Location (S City or Tow	n, State)			
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 2 Medical Examin 29b. Signature and title of certifier	cian: To the be er: On the basis and manner	o or examination	edge, death n and/or inve	stigation, ii	t the time, n my opin License n	ion, death occ	urred at the time, o	ause(s) and mate and place	, and due to the	he cause(s)	
10/K		30. Name and address of person who con	mpleted cause o	of death (Item 2	3a) (Type, P	D	UUS	845.) n	ARCH	129	2004	
Stat	te ar	NAUN CEASIN 31. Date filed (Month, Day, Year) MAR 3 1 2004	89. (P. Regis	Strar's Signatur	D'TAT	اک م	ret	T, B	ATIMO	NE	MD-	21201	

•		1 - For State Registrar 1. Decedent's Name (First, Middle, Las	State of Mary	land / Depa		lealth and N	Mental Hv	giene Reg. No. 2004		
Physi /Med Exam	dical	RUTH 4a. Facility Name (If not institution, give		SCHA		r Location of Death		7 , 2004 Year 4c. County of De.	1:00 A M	
Funera Directo		1 HAMILL COURT AP 5. Social Security Number 216-46-5852 6. Social Security Number		yrs. last birthday) 96 Yrs.	BALTIM If Under 1 Year Months Days	ORE If Under 24 Hrs. Hours Min.	8. Date of Birt Month, Da NOV - 2	N/ 1907	A irthplace (State or Foreign Country) MD	
Maryland a-f show	ctor	Usuat Residence of Decedent 10a. State 10b. County MD N/		c. City, Town or Lo		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			10d. Inside City Limits	
5-UUSO 72 hours after death with the Maryland 72 hours after 23a or 28a-f show natural, or Items 23a or 28a-f show	by Funeral Director	10e. Street and Number 1 HAMILL COURT A 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	PT. 56 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give X Year or Dates:		10f. Zip Code 21210 Was Decedent of HIYes, specify Cubit	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No	Black, White, etc.		
d within giene.	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)		dent's Usual Occup kind of work done DO NDT use retired EWIFE	during most of work		16b. Kind of Busines:	WHITE ss/Industry	
Men Men arke	To Be	17. Father's Name (First, Middle, Last) LOUIS 19a. Informant's Name/Relationship (7)	S.	HUTZ		THERESA		Maiden Sumame)	STRAUSS	
ore, es 1 an of Heal if Item 2		ANNA SCHAFFER ASC 20a. Method of Disposition 1 X Burial 2 Cremation 3 C	CHER / DAUGH	Ob. Place of Dispo	CENTRAL I sition (Name of natory or other place	PARK WEST	#9-C	NEW YORK, 20c. Location - City o	NY 10024 r Town, State	
2 2 E E E	SUCE	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen) B		. Name and Addre	ss of Facility SO		BALTIN SON & BROS PIKESVILLE		
He be executed / Medica Examine end wasician and partial-transit end burial-transit	al Examiner	23a. Part. Enter the disaase, or comp shock, or heart fature. List only of the shock of the shoc	COCOLO	nsequence of):		ig, such as cardiac		rest,	Approximate Interval Between Onset and Death	
law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physiclan/Medlo	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊡ No 9 □ Unknown	23c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3□	Ectopic pregnancy Dther (specify)	,		23d. Date of de Month	elivery Day Year	
w requires that been signed b	by	Part II. Other significant conditions of	ontributing to death but no	t resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute t	to the cause of death? robably 4 DUnknown	
The ate har page	Completed							med? death?	utopsy findings available completion of cause of s 2 \sumbox No	
Phys	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner Death 1 Accident Pending investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time of Injury	28c. Injur Wor	4 Nursing Ho	me 5 Resid	-	ecify)	
vital or Attending urs after death. ral Director: Afte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc. (S	pecify)			City or Tow			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral presents of the funeral p	Medical	29b. Signature and title of certifier	visician: To the best of my inner: On the basis of exa and manner stated.	mination and/or inv	29c. Licens.	pinion, death occur	red at the time, o	ause(s) and manner a late and place, and du 19d. Date signed (Mon MArch 2	e to the cause(s)	
	State	30. Name and address of person who of the state of the st	completed cause of death	MIN	Print)	on Men	print	to pind	Ball Md	
Regis		MAR 3 1 200	4 Stocker	15 100	all of					

			For	State of Maryla	nd / Depa	artment of	Health and	Mental Hygi	ene	1 00 00		
			1 - For State Registrar		Ce	rtificate o	f Death		g. 140	4 09890		
	Physici	an	1. Decedent's Name (First, Middle, Last)	_				2. Date of Death Month	Day Yes	. 1 0/ / 17/ 154		
7	/Medic Examir		4a. Facility Name (If not institution, give s			4b. City. Town	, or Location of Dec	3 eth	27 C 4c, County of D	9 8 434		
	LAdilli	ici	Univ. Marylo	and		13011-	-imale		Palti	MNO City		
	Funeral		5. Social Security Number 6. Sex	M 2□ F	. last birthday)	If Under 1 Ye		8. Date of Birth	(ear) 9. I	Birthplece (State or Foreign Country)		
	Director		414 34 8588 1€	VM ZDF	7 Yrs.			June 8,	1926 Т	ennéssee		
	yland sow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits		
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow in Madical Examiner must be notified at		ctor	Maryland N/A	1	Baltimo	re				1 Yes 2 □ No		
	vith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?		
	eath v	Funeral	1251 Washington	B LVd • 12. Was Decedent Ever in I	10 12		230	Canada Van as Na	U.S.	merican Indian.		
ထ	after d	Fun	1 Never Married 2 Marned	Armed Forces? 1 127 Yes 2 ☐ No If Yes, Give WW TT				Specify Yes or No- rto Rican, etc.)	Black, W	hite, etc.		
215-0036	ours a	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW	II	1 □ Yes 2 X N	lo Specify:		Specify: V	Inite		
5-	"natu	Completed by	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occ kind of work dor	ne during most of w	orking 10	6b. Kind of Business/Industry			
212	within iene. rthan	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		po not use reti cer / Pa	per Hange	er I	ederal G	overnment		
	be filed within that Hygiene. od other than event, the M	Be C	17. Father's Name (First, Middle, Last)				1	ame (First, Middle, Me	eiden Sumame)			
ylaı	should be filed within and Mental Hygiene. I marked other than armatic event, the M	To B	Troy Tha	cker					(not ava	ilable)		
Maryland	2 2 2 3		19a. Informant's Name/Relationship (Type		-			Rural Route Number,				
	Health tem 27		Troy M. Thacker 20a. Method of Disposition	20b.	Fall Way Westminster, Maryland 21157 Value of the place Date 20c. Location - City or Town, Stete							
Baltimore,	Peges nent of l int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other p		31/2004 Ba				
alti	permit. Pege Department of Important: If any injury of once.	l, î	21. Signature of Funeral Service Ligense			. Name and Add		Sonce Fune				
<u> </u>	20 E # 9	9 6	fleno ll	dridge			hie High	vay Balt	imore, Ma	aryland 21225		
П			23a. Parti. Enter the disease, or complic shock, or heart failure. List only on	e cause on each line.	th. Do not ent	er the mode of d	ying, such as cardia	ic or respiratory arres	t,	Approximate Interval Between Onset and Death		
W	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	# >C U	11)							
卷1.	Examiner			Due to (or as a conse	querica or,							
М.	ם ק	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):							
	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last									
760,	ite be ex iysician ne burial	calE	Due to (or as a consequence of):									
9	tificate ig phys as the											
Box	death certificat e attending phy d for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregn			3d. Date of delivery					
0	0 6 0	Physician/Med	1 Yes 2 No	4 Pregnant at time of e		Ectopic pregnan Other (specify)			Month	Day Year		
ď.	2 P 8	y Ph	Part II. Other significant conditions conf	tributing to death but not re-	sulting in the ur	nderlying cause g	given in Part I.	23e. Did toba	cco use contribute	to the cause of death?		
Records,	w requires been signi should be	ed by						1 ☐ Yes	2 □ No 3 □ I	Probably 4 Unknown		
၀၁	e law re has bee	Completed						24a. Was an	24b. Were	autopsy findings available		
		Com						autopsy performe 1 Yes 2	do death?			
Vital	ysician: Th	Be	25. Was case referred to medical examiner?	ospital:			Mh a	ath (Check only one)				
ō	Phys	. To	1 ☑Yes 2 ☐ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	28a. Date of Injury	Outpatien 28b. Time of	I JU DOA		dome 5 Residence		ecify)		
Division	nding F ath. r: After e funera	atlor	1 Vatural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury	28c. lnj W M 1 [ork? □Yes 2□No	20d. Describe now	injury occurred			
N S	after death. Director: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, office	•	28f. Location (Stree City or Town, S		Rural Route Number,		
a	pital o		200 C - 47 - 20 - 24 - 20 - 20									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Check only one) Check only 2 Medical Exemin	ician: To the best of my known: On the basis of examination and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and place opinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner a and place, and du	is stated. ie to the cause(s)		
	To th within To th comp	Me	29b. Signature and title of certifier	. •		29c. Licer	nse number	29d	Date signed (Mor	th, Dey, Year)		
	11.1		1 Jayul	MID		AUGI	764356	14399	3/27	104		
	571			npleted cause of death (Iter	n 23a) (Type, I	CALL	11 614	ene St	Rolt	-MD		
Į,	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature		V - C1		M(1	- '		
Total Contract	Registra	il.	MAR 3 1 200	14 1000	E4 A	. M.						

			1 - For State Registrar	State of M	aryland / Der	oartment e <i>rtificate</i>	of Hea	alth and eath	Mental Hy	/giene 2 (004	0989	
	Physic	ian	Decedent's Name (First, Middle, Last Lydia)	T7	_			2. Date of Do	eath Day	Year	3. Time of Death	
	/Medi Exami	cal	4a. Facility Neme (If not institution, give	street and number	Umpierr		own, or Lo	cation of Deat	March	4c. County	04 of Death	2222	
		Ш	6535 West Shady				dy S				e Ar	undel	
	Funeral Director		5. Social Security Number 6. Se 213-56-7625 Usual Residence of Decedent	х]м 21 <u>х</u>] F	ge (In yrs. last birthda 69 Yrs.			Under 24 Hrs Hours Min.	(Month, D.	1, 1934		olace (State or Foreig ntry) many	
	ryland how		10a. State 10b. County		10c. City, Town or	Location					1	0d. Inside City Limit	
	Ba-f s	Director	MD Anne Aru	nde1	Shady	Side						1 ☐ Yes 2X N	
	with ti		10e. Street and Number 6535 West Shady	Sido Pond		10f. Zip C	0764			10g. Citizen of V		ntry?	
	death	Funeral	11. Marital Status	12. Was Decedent			anic Origin? (S	pecify Yes or No o Rican, etc.)	USA 0- 14. Rac	e - Americ	an Indian,		
920	within 72 hours after death with the Maryland ane. than "natural; or items 23a or 28a-f show than Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Forces? 1 ☐ Yes 25☐ If Yes, Give Year or Dates:	No	If Yes, specify		Mexican, Puerl Specify:	o Rican, etc.)	Specify	k, White,	etc. White	
Maryland 21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Giv	edent's Usual (e kind of work DO NOT use	done durin	n ng most of wor	king	16b. Kind of Bu	siness/Inc	dustry	
212	77 70 5	Com	Elementary/Secondary (0-12)	College (1-4or	Casl					Casi	no		
nd	be filed tal Hygis d other	Be	17. Father's Name (First, Middle, Last)				18.	Mother's Nan	ne (First, Middle	irst, Middle, Maiden Surname)			
17	should by ind Menta i marked i marked	2	Ernst Bohme 19a. Informant's Name/Relationship (T)	ne Print)	10h Mai	ling Address /9			ailable		. City or Town, State, Zip Code)		
	os 1 and 2 of Health a item 27 is		Erika Boucher (D							hady Sid			
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 F	-	osition (Name ematory or othe	of		Date	20c. Location -				
Ħ.			* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		Metro Cı		Total medical		/2004	Baltimo	re, M	TD	
Ba	permit. Departr Imports any inje		Link OS	Enlo	†	22. Name and A Hardes 12. Rid	sty F	uneral	Home, I	P.A. polis, M	0.217	.01	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused ne cause on each lij	the death. Do not en	nter the mode o	of dying, su	uch as cardiac	or respiratory a	rrest,	219	Approximate Interval Between	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		Chronic Ken	of fa	ihue					Onset and Death	
	Examiner		f.	·	a consequence of):	4						O .	
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à consequence of).								
,	execut n and al-tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):								-		
8760,	icate be executed physician and the burial-transit	dicat	d										
9	n certifica anding ph use as t	/Med	IF FEMALE:	3c. If was autooma	of orogonous				_		7750-S		
.O. Box	death e atte	Completed by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	⊒Ectopic pregr ⊒ Other (speci				23d. Date Mon		y Day Year	
<u>α</u>	The law requires that the de ate has been signed by the a page 2 should be delached	y Ph	Part II. Other significant conditions con		ut not resulting in the t	underlying caus	se given in	Part I.	23e. Did to	obacco use contri	bute to the	a cause of death?	
ord	require sen sig	ted t	Dichetes Me	Witho					101	res 2□No	3 🔲 Proba	ibly 4 ∰Unknown	
3ec	has by	mple	Myperterion						24a. Was autop	osy pr	for to com	sy findings available	
la	in: Th ificate or, pag	e Co	25. Was case referred to medical	story Di	ronc				1 ☐ Yes	2 ⊠ No 1	eath?	2□ No	
Ţ	Physician: this certificaral director, p	To B	examiner?	ospital:	nt 2 ER/Outpatie	nt 3 DOA	Othon		h <i>Check only o</i> ome 5.74 Resid	ne) dence 6 □Othe	(Specify)		
Division of Vital Records,	ing Ph	on:	27. Manner of Death 1 Sanatural 5 ☐ Pending	28a. Date of Injui (Month, Day	y 28b. Time o	of 28c.	Injury at Work?			now injury occurre			
Sio	Attend death ctor: A y the fi	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	ıry - At home, farm, st	M reet factors of	1 ☐ Yes	2 🗆 No	296 Location /C	Standard Million L.	0	0	
2	s after s after al Dire ed in b	Certification:	4 Homicide determined	building, etc	(Specify)	ieer, ractory, or	TIC8		City or Tow	Street and Number In, State)	r or Hurai	Houte Number,	
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edicai (29a. Certifier 1 S Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	of my knowledge, deat examination and/or in ted.	h occurred at the	he time, da my opinion	ate and place, n, death occur	and due to the d red at the time, o	cause(s) and man date and place, ar	ner as sta nd due to t	ted. he cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier				cense num			29d. Date signed			
	^	_	Mallongn			D-	405	21		month ?		•	
	7		30. Name and address of person who could be CHANEY	mpleted cause of de	eath (Item 23a) (Type,	Print) 325	HO	SPITAL	DRIVE E, MD	SuiTE 21061	20	8	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 3 1 2004	32. Registra	r's Signature)	A CONTRACTOR OF THE PARTY OF TH	-11.50				

			State of Ma -b,27,Per ME,	6830,4/23 <i>E</i>	ertificate of	Death		-	3004	09892			
Physician /Medical	1. Decedent's Nam Richar	ne (First, Middle, La d	G.		Wilson	i	2. Date of D Month MARCH	Day	Year 2004	3. Time of Death 0852 A			
xaminer			e street and number) LS HIGHWAY							4c. County of Death ANNE ARUNDEL			
eral ctor	5. Social Security 5 7 7 - 8 6	-1631 i	ex 7. Age XOXM 2□F	(In yrs. last birthda 45 Yrs.	Months Dave		8. Date of B (Month, D June 2	irth lay, Year) 2,1958		place (State or Foreign intry)			
The roust be notified at	Usual Residence	10b. County		10c. City, Town or	Location					10d. Inside City Limits			
rector	MD 10e. Street and Nu	Queen	Annes					10a Cirina	n of What Cou	1 ☐ Yes 21 No			
aDi	3017 L	ovepoint 1	Road		10f. Zip Code	1666			USA	intry r			
by Funeral Director		ried 2 🛣 Married 4 🗆 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XXV If Yes, Give Year or Dates:		3. Was Decedent of tr Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	0- 14.	Race - Amen Black, White				
eted	(Spe	15. Decedent's Ec	lucation de completed)	(Gi	cedent's Usual Occu	during most of work	ina	16b. Kind	of Business/Ir	ndustry			
Completed	Elementary/Sec 12	ondary (0-12)	College (1-4or 5+	·)	. DO NOT use retire wner	9d)		Annap	olis P	aving			
Be		(First, Middle, Last) n H. Wilso	n n			18. Mother's Nam		, Maiden Sui	mame)				
J _o		lame/Relationship (19b. Ma	iling Address (Stree	Rosa Sz		or City or To	oum State 7	n Codo)			
		ilson (Mot				Beach Roa							
	20a. Method of Dis	position	Removal from State	120b. Place of Dis	position (Name of rematory or other pla		Date CIO		ion - City or To				
		5 Other (Specify			rematory	3/31/	2004	Balti:	more,	MD			
	21. Signature of Euneral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A.												
		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
	shock, or hea				inter the mode or ay	ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death			
1	disease or condition resulting in death)	on	a. Pontine Her	consequence of):									
					lerotic Car	diovascular	Disease						
Examiner	Sequentially list concerning to it cause. Enter Under Cause (Disease or	onditions, amediata	U	consequance of):									
Ea	Cause (Disease or that initiated event resulting in death)	5	c										
9	roodking in oddiny			consequence of):									
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by Physician/Medic	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2	months?	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir	Fetal death 3	☐Ectopic pregnanc☐ Other (specify) _	у		ľ	Date of delive	ery Day Year			
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	Part II. Other signi	ficant conditions co	intributing to death but	not resulting in the	underlying cause giv	ven in Part I.		obacco use c Yes 2⊠,No		ne cause of death? ably 4 Unknown			
									prior to cor death?	psy findings available inpletion of cause of			
Completed					0.1	26. Place of Death							
Be	25. Was case refer examiner?		Hospital:		ent 3 DOA Oth	4 LI Nursing Hol	ne 5 🗌 Resid			, AT SCENE			
To Be		No	Hospital: 1 ☐ Inpatient 28a. Date of Injury		of 28c law	n/ at	cod. Describe i	low injury occ	currea				
To Be	examiner? 1 XYes 2	No	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y		Wor	yat rk? Yes 2 □ No							
To Be	examiner? 1 XYes 2 2 27. Manner of Deat 1 Natural	No h 5 ☐ Pending	1 Inpatient	/ear) 28b. Time Injury	M 1 🗆	Yes 2 □ No	28f. Location (S City or Tox	Street and Nu vn, State)	imber or Rura	l Route Number,			
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		-	For State Registrar	State	of Marylai		artmen rtificate					giene (004	09893	
			Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physici /Medio		Lillian C. Wrig	ht							March	17	2004	5:50 P M	
	Examir	_	4a. Facility Name (If not institution,	give street and I	number)		4b. City,	Town, or	Location	of Death			inty of Death		
П			Bayside Care Ce	nter					on Pa				Mary'	S	
	Funeral		5. Social Security Number	S. Sex		. last birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl (Month, Da)	Year)	Cou		
	Director		043-14-7114	1□M 2/CXF	81	Yrs.					May 19,	1922	Conn	ecticut	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	ocation							10d. Inside City Limits	
	anyia sho	7											1 ☐ Yes 2XGNo		
	188-f	ecte	MD St. Ma	ry's	Cha	rlotte	Hall 10f. Zip	Code				10a. Citizen	of What Cou	ntry?	
	with t	ā		77 - 1 1 D	3			622				_	S. A.	,	
	s 236	Funeral Director	29449 Charlotte			118 12			spanic Ori	igin? (Sp	acify Yas or No-		Race - Amen	can Indian.	
	er de Item	ű	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie		ecedent Ever in 1 Forces? s 2 □ No	0.0.	If Yes, spec	ify Cuba	n, Mexicar	n, Puerto	ecify Yes or No- Rican, etc.)	E	Black, White,		
36	rs aft	byF	3 ☑ Widowed 4 ☐ Divorced	If Yes.		TT	1 🗆 Yes	XX No	Specify:			Spe	whi	te	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show to Madical Examiner cust be notified at	Pa	15. Decedent's			16a, Dece	dent's Usua	al Occupa	ation			16b. Kind o	f Business/In		
15	n "n	Completed	(Specify only highest Elementary/Secondary (0-12)	1	d) e (1-4or 5+)	(Give	kind of wo DO NOT us	rk done d se retired	luring mos)	t of work	ing	Feder	ral Po	wer	
712	should be filed within and Mental Hygiene. s marked other than " umatic event, the Mar	E	Elementary/Secondary (0-12)	1	(1-401 54)	Secre	tary	to t	he Co	mmis	sioner	Comm	ission		
	i Hyg other		17. Father's Name (First, Middle, L	ast)					18. Mothe	er's Name	e (First, Middle,	Maiden Sun	name)		
lan	ic ev	To Be	Joseph Colos Anna Marcinkas												
Maryland	should ind Men in marke	_	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street a	and Numb	er or Run	al Route Numbe	r, City or To	wn, State, Zij	o Code)	
Σ	and 2 Balth a n 27 ls		Joyce A. Westbe	rry/Dau	ghter	8753	Dove	Dri	ve Be	1 A1	ton, Ma	ryland	1 2061	1	
ā,	- I a =		20a. Method of Disposition		1	Place of Dispo	sition (Name	ne of ther plac	e)	Mar	Date	20c. Location	on - City or T	own, State	
Ę	Pages nent of I int: if it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			dar Hi				22, 2		Suitla	and, M	aryland	
Baltimore,	permit. P Depertm Importa any inju		21. Signature of Funeral Service L		4									1.Hme., P.A.	
ä	Depermine Depermine any ir once.		Joseph 180	Som o	MOC MOC									MD 20622	
,1200	eath certificate be executed attending physicien and attending physicien and in one as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Sever		- P	ne	an	on				Onset and Death	
99	ntifica ng ph as th		IF FEMALE:												
P.O. Box	the death certifica y the attending ph iched for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1□Liv 4□Pr	outcome of pregine birth 2 Fe egnant at time of iknown	tal death 3	⊒Ectopic pr ⊒ Other (sp					23d.	Date of deliv Month	ery Day Year	
	requires that the de- een signed by the a nould be detached f	þ	Part II. Other significant condition	ns contributing to	o death but not re	esulting in the u	inderlying o	ause giv	en in Part	l.		obacco use d 'es 2□N		the cause of death? bably 4 ⊠Unknown	
Records,	e law has b	Completed									24a. Was autop perfor	an 24 sy med? 2 5 No	b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available ompletion of cause of 2 No	
ä	ician: Th certificete rector, pag	Be	25. Was case referred to medical						26. Place	e of Deat	h (Check only o	ne)			
†	Phyeician: this certific ral director,	10	examiner? 1 ☐ Yes 2 🖔 No	Hospital:	☐ Inpatient 2	☐ ER/Outpatie			41.41	ursing Ho	ome 5 ☐ Resid	ence 6 🗆	Other (Speci	fy)	
0			27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Da	ite of Injury fonth, Day Year)	28b. Time of Injury	of 2	28c. Injun Work	/ at k?		28d. Describe h	ow injury oc	curred		
<u>0</u>	Attending r death. sctor: After y the fune	atic	2 ☐ Accident investig	ation			М	1 🗆	Yes 2	No					
Division of Vital	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 256. Pl	ace of Injury At		reet, factor	y, office			28f. Location (S City or Tox		umber or Rur	al Route Number,	
۵	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	al Cer	29a. Certifier 1 Certifying	Physician: To	the best of my ki	nowledge, deal	th occurred	at the tin	ne, date a	nd place,	and due to the	cause(s) and	I manner as s	stated.	
	e Ho	ledical	(Check only 2 Medical one)		e basis of examination of the state of the s	nation and/or in	rvestigation	, in my o	pinion, dea	ath occur	red at the time,	date and pla	ce, and due t	to the cause(s)	
_	To th Withir To th comp	Me	29b. Signature and little of pertition	11	~		29	c. Licens	e number			29d. Date sig	gned (Month,	Day, Year)	
	2121		1	1			D	199	17			3/	26/0	4	
	ST		30. Name and address of person	who completed c	ause of death (It	em 23a) (Type	Print)					-	1		
				1			h Roa			nia,	Maryla	nd 206	519		
	St Regist	ate	31. Date filed (Month, Day, Year) MAR 3 1	2004	- 1			uls							

				ype or Print in B							
			For State	State of Maryland	d / Depa	artment of Heal rtificate of Dea	ith and Me			14 09894	
			Registrar 1. Decedent's Name (First, Middle, Last)			illicate of Dea		Reg	g. No.	3. Time of Death	
	Physicia	an	VIVIENNE V	ERA WILSON				Month	Day Ye	004 2 52 AM	
1	/Medic Examin		4a. Facility Name (If not institution, give s.			4b. City, Town, or Loca		THINCH	4c. County of E		
	Examin	eı	GOUD SAMARI		TAL	BALTIM	ORE		N/A		
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. In AX) 83	ast birthday) Yrs.		Inder 24 Hrs. 8	Date of Birth (Month, Day, eptember 2	9. 28,1920 N	Birthplace (State or Foreign Country) Pary I and	
	pu ,	ļ	Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	ocation				10d, Inside City Limits	
	faryla sho	ō	Maryland Baltimor		owson					1 ☐ Yes 2 ☐ No	
	28a-	Director	10e. Street and Number		0W3011	10f. Zip Code		10	g. Citizen of Wha		
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene trems 23a or 28a-f show them 27 is marked other then "natural", or thems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	O E	1055 West Joppa R	oad		2120	4		USA		
	oms 2	Funeral	11. Marital Status	Was Decedent Ever in U.s Armed Forces?	S. 13.	Was Decedent of Hispan If Yes, specify Cuban, Me	ic Origin? (Spec exican, Puerto Ri	fy Yes or No- can, etc.)		American Indian, Vhite, etc.	
36	filed within 72 hours after death with the Maryland Hygiene. Wher then "natural", or items 23a or 28a-f show with the Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X X to lf Yes, Give Year or Dates:		1 ☐ Yes 2XX No Sp	ecify:		Specify:	White	
8	hour	ed b	15. Decedent's Educ		16a. Dece	dent's Usual Occupation		1	6b. Kind of Busin	ess/Industry	
215	nin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done during DO NOT use retired)	g most of working	7			
21	ad wit	Con		2	<u> </u>	lomemaker			0wn l	lome	
Maryland 21215-0036	2 should be filed with and Mental Hygiene. Is marked other ther sumatic event, the	To Be	17. Father's Name (First, Middle, Last) Frod Loctor Simon	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vera Heckman							
Z	d Mer d Mer narks natic	T _o	19a. Informant's Name/Relationship (Typ	a Print)	19h Maili	ng Address (Street and N			City or Town. Sta	te. Zin Code)	
Ma	and 2 s ealth an n 27 Is I		Jeffrey H Wilson	Son						ryland 21030	
ē,	s 1 and 3 if Health Item 27 other tra		20a. Method of Disposition	20b. P	lace of Dispo emetery, crea	osition (Name of matory or other place)	Da	te 2	Oc. Location - City	or Town, State	
imo	Page nent o ant: If ury or		1 ☐Burial 2 XX remation 3 ☐Ri *4 ☐Donation 5 ☐ Other (Specify)	Gre Gre	enmour	nt Cemetery	3/30/0			e, Maryland	
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21 Sunature of Funeral Service License	en Kenaku	2		6500 York	Road Balt	timore, Ma	ral Home Inc ryland 21212	
F	£		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death e cause on each line.	n. Do not en	ter the mode of dying, su	ch as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	ASPIRAT	ION	PNEUN				Onsor and Osais	
	/Medical Examiner		resulting in death)	Due to (or as a consequ		113416-					
		er	Sequentially list conditions,	CARCINI Due to for de a consequ		LUNG					
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	CARCING	AMC	BREAS	ST				
o,	be executed iician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
3760,	eath certificate be executed attending physician and for use as the buriat-transit	lcal									
89 x	ertific ding p	Physician/Medic	IF FEMALE:	3c. If yes, outcome of pregna				22d Date of	f delivery		
Вох	attende for us	clan	in the past 12 months?	1 Live birth 2 Fetal	death 3	∃Ectopic pregnancy ∃ Other (specify)		23d. Date of 6 Month		Day Year	
P.O.	the d by the ached	hysl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown							
	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	by P	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	inderlying cause given in	Part I.			te to the cause of death?	
ord	w require been si							1 Yes		Probably 4 Onknown	
of Vital Records,	law in has be	Completed						24a. Was an autopsy perform	24b. Wer prior deat	e autopsy findings available r to completion of cause of b?	
al F	n: The							1 ☐ Yes 2	DK6 10	Yes 2□ No	
V.	siclan: The law s certificate has t lirector, page 2 s	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2	ER/Outpatie	Other	Place of Death		nce 6 Other (Specify)	
of	g Phy er this ieral d	—	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of				w injury occurred	opasity)	
ion	Attending or death. ector: After by the fune	atlo	t√Natural 5 ☐ Pending investigation	(Month, Say 7 Sar)	mqury	M 1 ☐ Yes	2 🗆 No				
Division	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office	28	Bf. Location (Str. City or Town,	eet and Number o State)	r Rural Route Number,	
_	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C		sicien: To the best of my kno ner: On the basis of examina and manner stated.							
	To thi Within To the	Me	29b. Signature and title of certifier			29c. License nur	mber	29	d. Date signed (A	fonth, Day, Year)	
	0	+	Dai Tono	M.D.		RES -	000	~	MARCH,	28,2004	
	10		30. Name and address of person who co SHILPA D. GAITO			Print) RAVEN BL	VD, BA	ALTIMI	ORE , M	1021239	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	turn	bach		-	,		
	Regist	rar	MAR 3 1 2004	Alexander /	7	y very					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () 4 09895 State Registra AMEND ITEM #26 PER PHY G830 4/19/04 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1338 WHITE LEROY O 13 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HOSPITAL SECOUR 8. Date of Birth (Month, Day, Year) Jan. 16, 1946 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Days Hours 1₹M 2□F 58 216 42 9236 Yrs. MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Maryland N/A Baltimore 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number 2219 W. Pratt Street 21230 U.S. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 | Yes 2 | No
If Yes, Give Unknown
Year or Dates: Unknown 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 ☑ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manager Bar unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joseph Laumann 843 Swift Road Pasadena, Maryland 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 3/26/2004 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final yours. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 1-hour resulting in death) Due to (or as a consequence of): Louary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): K that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown throat Concer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home -5 Nursing Home -5 Nursing Home -5 Nursing Home -5 Nursing Home -6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of

/Medical Examiner the death certificate be executed and Box 68760 the attending physicien detached for Ö The law requires that ed bluods page 2 s Vita in by the funeral director. of Division Hospital or Attending death. after death Director: within 24 hours a

Examiner Completed by Physician/Medical Be

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or lier any injury or other fraumatic event, the Medical Enamedance.

Physician

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed by

Be

2

traumatic event, the Medical Examiner must be notified at

Medical Certification: To

25. Was case referred to medical examiner?

Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

4 Homicide 29a. Certifier

Escertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 □ Yes 2 □ No

29c. License number 00 12753

SE COURS HOSPITAL

29d. Date signed (Month, Day, Year)

2000 W. BALTIMORE ST

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

alvatore

SALVA TORE

32. Registrar's Signature

Lain

RAITI

31. Date filed (Month, Day, Year)

MAR 3 1 2004

State Registrar

		ŀ	For State Registrar	State of Maryland / Depa	artment of Health and I		iene _{sg. No.} 2004 0989	6	
	Physicia /Medic		Decedent's Name (First, Middle, Last, LILLIAN	Р	WEINSTEIN	2. Date of Deat Month MAR	26 2004 7:40A	M	
	Examin		4a. Fecility Name (If not institution, give JOSEPH RICHEY HOS 5. Social Security Number 6. Se	SPICE x 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death BALTIMORE If Under 1 Vear 1 II Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	4c. County of Deeth N/A 9. Birthplace (State or Fore	sign	
Ä.	Director		Usual Residence of Decedent	M 2 X F 85 Yrs.		JAN 20°,		-	
e Maryland Ba-f show	ector	MD 10b. County MONTGOME	RY SILVER		10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	th with the 23a or 2 ust be no	Funeral Director	11700 OLD COLUMBI		10f. Zip Code 20904		Og. Citizen of What Country?		
036 urs after deal al', or Itams 2	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Menial Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic svent, the Mudical Examinar must be notified at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ሺ Widowed .4 □ Divorced	1 □ Yes 2 V No	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert 1 Pes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE		
21215-0036	filed within 72 he Hygiene. kher than "natui ant, the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	le completed) (Give	dent's Usual Occupation kind of work done during most of wor DO NOT use retired) OMEMAKER	king	16b. Kind of Business/Industry		
Maryland 2	2 should be filed and Mental Hygis is marked other aumatic avent, II	To Be C	17. Father's Name (First, Middle, Last) ELLIS	PRESS	REBEC		TAYLOR		
	1 and 2 sho Health and I am 27 is ma	1 3	19a. Informant's Name/Relationship (T) SANDRA HELTZMAN (ng Address (Street and Number or Ru OLD COLUMBIA PIL	KE SILVE	R SPRING, MD 20904		
Baltimore,	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 1 □ Donation 5 □ Other (Specify,	HEBREW Y	OUNG MEN 3/28	3/04	BALTIMURE, MD		
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Septice Licens	8	2. Name and Address of Facility 50 900 REISTERSTOWN	RD. PIKE	SVILLE, MD 21208		
	Physician /Medical		23a. Part1. Entey the dishase, or comp shock, or yeart failure. List only of Immediate Cadse (Final disease or condition resulting in death)	lications that caused the death. Do not ent ne cause on each line. a	1.	or respiratory arre	Approximate Interval Between Onset and Death		
760,	te be executed ysicien and burial-transit	cal Examiner	Esquentially fict conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):	cular disease				
.O. Box 687	The law requires that the death centificate be executed the has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12, months? 1 Yes 2 ENo 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year		
Ω.	w requires that the second of	d by Ph	Part II. Other significant conditions co	entributing to death but not resulting in the u	nderlying cause given in Part I.		pacco use contribute to the cause of death?		
Records,	The law rec ate has been page 2 shou	Completed by				24a. Was a autops perform 1 Yes 2	y prior to completion of cause	bie of	
· Vital	Physician: The I this certificate har al director, page	To Be C	25. Was case referred to medical examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	ath (Check only on		2	
ion of	ling Ph		27. Manner of Death 1		f 28c. Injury at Work? M 1 Tyes 2 No	28d. Describe ho	w injury occurred		
Division	To the Hospital or Attanowithin 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify)		City or Towr			
	ne Hospi n 24 hour ne Funer sletely fill	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Example 1	ysician: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	a, and due to the caurred at the time, do	ause(s) and manner as stated. ate and place, and due to the cause(s)		
	To the vithing to the comp	Σ	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month, Day, Year) March 26, 2004		

State Registrar

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30. Name and address of person who comp E To MD Rick 31. Date filed (Month, Day, Year) MAR 3 1 2004

838 NEntaw St

Lillian Weinstein 3/26/04 720A

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Р. м March 11, 2004 5:35 Maria Luisa Aguilar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ XF Months Yrs. Nov. 26, 1904 Puerto Rico 99 Director 142-22-7690 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State d other than "natural", or Itams 23a or 28a-1 show event, the Medical Exprimer mast be notified at 1 X Yes 2 No Director Chevy Chase Md. Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A 20815 3513 Bradley Lane Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If item 27 Is marked other then "natural", or Ita 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1♥Yes 2□No Specify: Puerto Rican Baltimore, Maryland 21215-0036 Specify: White þ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maria Rodriguez Ouentin Padilla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3513 Bradley Lane, Chevy Chase, Md. 20815 Manuel Thomas Aguilar / Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury of ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) March 15, 2003 North Arlington, N.J. 21. Signature of Funeral Service Licens 22. Name and Address of Facility
DeVol Funeral Home Pmy 2222 Wisconsin Ave. N.W. Washington, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acuke myo cardial infarction
Due to (or as a consequence of): 5 days **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Unknown Hypoxemia, end-stage renal disease, congestive heat 1 Yes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No failure, septic shoulder autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Inle M.D. 56439 MD rumos 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Dr. Shann Turban 9901 Medical Centar once, Rockville, MD 20850 31. Date liled (Month, Day, Year) 32. Registrar's Signature State MAR 17 2004 oaks Registrar

DHMH 17 Rev 1/2001

Aguilar, Marie

State of Maryland / Department of Health and Mental Hygiene 2001 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 11:05A M **Physician ADAMS** NELLIE March 16,2004 /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY Silver Spring Mariner Health Silver Spring Il Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Sept. 24,1923 9. Birthplece (Stete or Foreign Country) Carolina 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1□M 20F 80 577-42-4290 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County 28a-f show Examiner must be notified at Silver Spring 1 Yes 2 No Montgomery MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ 20910 U.S.A. 1400 Fenwick Lane, #811 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give filed within 72 hours after 1 Never Married 2 Married 0. Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: δ **¾** Widowed 4 □ Divorced "neturel" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Mudical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) than Elementary/Secondary (0-12) 8th Domestic Home other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be file partment of Health and Mental Hy portent: If Item 27 ie marked oth y injury or other traumatic event £8. Be Nellie G.McCall Clarence Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5010 38th Ave., Hyattsville, MD 20782 John A. Jones (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem 3/22/04 | Silver Spring, permit. Page Department Importent: If eny injury o 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Signature of Funeral Service Gens 246 N. Washington St Rockville, Approximate Interval Between Onset and Death 23a. Pentl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fature. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) General Debility Physician /Medical Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter the conting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed **burial-transit** Deh dration and Due to (or as a consequence of) P.O. Box 68760, attending physicien Depression use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ page 2 should be Rheumatoid Arthritis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Anemia of Chronic Disease autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturat 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: / 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number owa D00058965 Mar. 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20852 11119 Rockville Pike #100, Rockville, MD Saima U. M.D. Khawaja,

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) MAR 19

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001,

1- For AMEND#10-coerFH3/24/04, BW, MCO
Registrer/AMEND#1perMF3/24/04, BW, MCO
Certificate of Death 09899 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Helen Hardy Bazemore Yeer **Physician** Helen Harhy Bazemore 03 15 12:40p 2004 /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly

Open If Under 24 Hrs.

Min. Prince George Prince George Hospital Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 05/07/29 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 🗀 F Yrs. 579 56 8216 N.C. 74 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Mitchellville 28a-1 show must be notified at Prince George - Fort Washington Md 1 ☑ Yes 2 ☐ No Director the 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20721 10403 Fairlakes Terrace USA Ітеть 23а Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If tem 27 is marked other the any injury or other trainments. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Patient Assistant 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Hardy Eva Tynes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10403 Fairlakes Terrace Mitchellville, Md Zoe Early Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 3/17/04 Riverdale, Md Riverdale Park * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Shead Funeral Home & Cremation Service 5732 Georgia Ave NW Washington, DC20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ARDIAC ARRHYTHMIA **Physician** MATAL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner if or Attanding Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physicien and d in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760, by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2Xi No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ▼ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 182 March 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

8 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Dr C Donald George

32. Registrar's Signature

Hospital Dr Cheverly, Md 20785

#001

			1 - State of Ma	ryland / Dep <i>Cε</i>	partment of Health and ertificate of Death		giene2004	09900
			Decedent's Name (First, Middle, Last)			2. Date of Dea Month	ath Day Year	3. Time of Death
	Physicia /Medic		Eva Geraldine Bartgis			March 2	25,2004	8:00 A M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	eath	4c. County of Death	
			Frederick Memorial Ho	spital	Frederick		Frederic	
	Funeral		1 N 2 X E	(In yrs. last birthday	Months Days Hours N	Ain. (Month. Day	v. Year) Cour	lace (State or Foreign ntry)
	Director		220-28-7850 Usual Residence of Decedent	69 Yrs.		March /	, 1935 Mary	Land
	and		10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
	Mary	ō	Maryland Frederick	Frederick				1 □ Yes 2XXXNo
	the 28a	rec	10e. Street and Number	TICUCTION	10f. Zip Code		10g. Citizen of What Cour	itry?
	3a or		6620 Linganore Road		21701		USA	
	ms 2	Funeral Directo	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Po	? (Specify Yes or No-	14. Race - Americ Black, White,	
9	or Ite	Fu	1 Never Married 2 Married 1 Yes 2 No	5	1 ☐ Yes 2 X No Specify:	delto ricali, etc.)	Specify:	etc.
21215-0036	ours reft,	d by	3 Widowed 4 □ Divorced Year or Dates:		12.00 24.10 000).		Whi	te
2	72 h "netu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dec	edent's Usual Occupation e kind of work done during most of DO NOT use retired)	working	16b. Kind of Business/Inc	dustry
7	within the the the the the the the the the the	mp	Elementary/Secondary (0-12) College (1-4or 5-1	self	DO NOT use retired)		h om om a le o m	
7	be filed within 72 hours after death with the Maryland nat Hyglene. dd other than "neturel", or Items 23a or 28a-f show event, I're Madfral Examinationals.		17. Father's Name (First, Middle, Last)	Sett	18. Mother's	Name (First, Middle,	homemaker Maiden Sumame)	
Maryland	@ O &	Be c	Merhl Richard Perkins			et Lucinda		
2	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, Ire M	10	19a, Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street and Number of			Code)
<u>≅</u>	od 2 s Ith ar 27 is 1reu		David Bartgis, son	5732	Jefferson Pike,	Fredeick	Maryland (21701
ē,	Hea Hea tem other		20a. Method of Disposition	20b. Place of Disc		Date	20c. Location - City or To	
OE.	ages ent of ht: #1		1 X Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)			29/2004	Frederick, N	Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic ex		21. Signature of Funeral Service Licensee		22. Name and Address of Facility		Basford Fur	neral Home
ñ	Depar Impo any ir		Knay M. Deises		06 East Church S			
			23a. Part 1. Enter the disease, or complications that caused shock, scheart failure. List only one cause on each line	the death. Do not e	nter the mode of dying, such as car	diac or respiratory arr	rest,	Approximate Interval Between
П	Physician		Immediate Course /Final	Revino	u ia			Onset and Death
	/Medical		resulting in death)	consequence of):				
	Examiner		Sequentially list conditions b. Car	onic Ob	structive Poly	ronaus L	Disease	
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of):				
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9	ires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23c. If yes, outcome of	of pregnancy			201 Date of date	
Вох	atten atten for us	ian	in the past 12 months?	2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	Day Year
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	that led by deta		Part II. Other significant conditions contributing to death bu	t not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to the	ne cause of death?
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202	w requir been si should	lete	Saizure	////		24a. Was a	an 24b. Were auto	psy findings available
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	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific: completely illed in by the funeral director,	edicai	29a. Certifier (Check only) Certifying Physicien: To the best of	examination and/or i	ath occurred at the time, date and pl investigation, in my opinion, death o	lace, and due to the o occurred at the time, o	cause(s) and manner as si date and place, and due to	tated. the cause(s)
	the hin 2 the I	Med	one) and manner state 29b. Signature and title of certifier	ed.	29c. License number		29d. Date signed (Month,	Day Yearl
	To To		200. Signature and the or definitely	MAIN	D3719	7	3.75	04
7	1		20 Name and address of the	oth (Item 22a) (Time	Print)	/	5-65-	
	\mathcal{D}		30. Name and address of person who completed cause of de	/ (Item 238) (Type	7+4 St F	nodoni	3-25- KMD 2	7/70/
	Sta	te	31. Date filed (Month, Day, Year) 32. Registra	r's Signature		Eacrice	The contract of the contract o	
	Registi		MAR 3 1 2004	Patrice D	Carry 5			

			1 - For State Registrar	State of I		d / Depa		f Health	and M		giene Reg. No.	2001	09	90
Sec. 38	Physici /Medio		Decedent's Name (First, Middle, Last Lucy Adina Benne							2. Date of De Month March	Day	2004 ^{Year}	3. Time of 2:37	Death A M
1	Examir		4a. Facility Name (If not institution, give Holy Cross Hospi		er)			n, or Location				county of Deeth		
100	Funeral		Social Security Number 6. Se			last birthday)	If Under 1 Y	ear If Unde	er 24 Hrs. Min.	8. Date of Birt (Month, Day March	h y, Year)	ontgome 1	olece (State or	r Foreign
o T	Director	į.	577-02-9607 Usual Residence of Decedent	1 1 2 LA	67	Yrs.				March	30, 1	.936 .	Támaica	
	lahow	ō	10a. State 10b. County Maryland Prince Ge	owas ta		y, Town or Lo	cation						10d. Inside Cit	-
	th the A or 28a-1	lrect	10e. Street and Number	orge s	Lai	ham	10f. Zip Coo	de			10g. Citize	en of What Cou	ntry?	
	s 23a	rai	9601 Woodland Ave		at Francia II	5 1401	2070		N-1-1-0 (C		Jamai		and the disease	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 ahow any injury or other traumatic event, it a Maxifical Examination could be made.	Completed by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date:	s? ₫ No	1	was Decedent f Yes, specify (1 ☐ Yes 2)()			cify Yes or No- Rican, etc.)		I. Race - Americ Black, White, Specify: B1		
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Maryland 21215-0036	ould be file Mental Hy arkad oth	To Be (17. Father's Name (First, Middle, Last) Samuel Bennett					Lou	ise S			,		
	nd 2 sh lith and 27 is rr r traurr		19a. Informant's Name/Relationship (T) Horace Malcolm	рө, Print) (son)						Route Numbe		Town, State, Zip 20782	Code)	
Baltimore,	ages 1 au ent of Hea nt: If item		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	temoval from Sta		lace of Dispo emetery, cren	sition (Name o natory or other Heaven	f place)	Da	ate	20c. Loca	r Sprin		
Baltii	permit. P Departm Importar any injur		21. Signature of Funeral Service Licens	"Olylu	un	22	. Name and Ad	dress of Faci	lityMcGu	ire Fu	neral	Service gton, D	e.	012
760,	Physician /Medical Examiner but sician and butian-Itausit sthe putial-Itausit	Ilcal Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events resulting in death) Last	Due to (or a Seps	tensi	on uence of): uence of):							Approximate interval Between Onset and D sudden Days Days	eath
P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fete at time of d	death 3	Ectopic pregna Other (specify				230	d. Date of delive Month	-	ear
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ion of	Phy this ald	atlon: To	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L	ijury	28b. Time of Injury	28c. li	njury at Work?	21	e 5 ☐ Resid		Other (Specify	")	
Divis	al or Attences after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At ho etc. (Specify	ome, farm, stre	eet, factory, offi	ce	21	8f. Location (S City or Tow	treet and N n, State)	Vumber or Rura	Route Numb	er,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Phy- (Check only one) 2 Medical Exami	sician: To the bearing: On the basis and manner	of examinat	wledge, death tion and/or inv	occurred at the restigation, in m	e time, date a ny opinion, de	nd place, ar ath occurre	nd due to the c d at the time, d	ause(s) an late and pla	nd manner as st ace, and due to	ated. the cause(s)	
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X			30. Name and address of person who co	impleted cause of	death (Item	23a) (Type, I		32332		M	larch	15, 200)4	
			Suresh K. Gupta, 31 Date filed (Month, Day, Year)		801 G		Avenue	Ste.	2-20,	Silver	Spr	ing, MD	2090	2
	Sta Registr		MAR 18 200		strar's Signa	B	Span	Es/						

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 Physician MARCH 16, 9:15 P. BERGMAN
4b. City, Town, or Location of Death /Medical LILLIAN 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner CHEVERLY PRINCE GEORGES GENERAL HOSPITAL PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) DEC. 24,1911 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗶 F Months 92 Director 216-58-9451 POLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-1 show ust be notified at Director 1X Yes 2 □ No MARYLAND PRINCE GEORGES BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23s or 16300 BANBURY LANE 20715 UNITED STATES OF AMERICA Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. The Madical Examiner: filed within 72 hours after 1 ☐ Yes 2 XNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 SpecifyWHITE 1 ☐ Yes 2 🛣 No Specify: þ Year or Dates: 3 XWidowed 4 □ Divorced "netural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked I any injury or other traumatic evense. JOSEPH FRIEDMAN TOBY NATABOCH ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHILIP S. BERGMAN - SON 105 ELM AVENUE, GLEN BURNIE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MT. LEBANON CEMETERY 03/18/2004 ADELPHI, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY GOLDBERG MEMORIAL CHAPEL, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic Obstructive Pulmonary Disease 15 years /Medical Due to (or as a consequence of) Examiner Congestive
Due to (or as a consequence of): Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5 years Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Box 68760 Completed by Physiclan/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ZNo 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physician: Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 TYes 2 TNo death. after death 2 Accident 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide pelli within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tembers 00012015 3-17-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steinberg 6492 Landover Rd Landover MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State oacks MAR 19 Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2004 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) March 13, 2004 **Physician** Ba.11 Jr. 7:33 AM Elmer /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner Takoma Park Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Foreign Country) Washington, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 ☑ M 2 □ F 579-42-1887 80 DC Director Usuel Residence of Decedent 10d. Inside City Limits 10a Stete 10b. County 10c. City, Town or Location 7 is marked other than "naturel", or items 23e or 28e-f show traumatic event, the Modical Examiner must be notified at Hvattsville 1 □XYes 2 □ No MD P.G. **Funeral Director** 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Heelih and Mental Hygiene. And the file of Heelih and Mental Hygiene. And I liem 27 is marked other than "natural; or thems 23e or Jry or other traumatic event, the Medical Examiner must be any or other traumatic event, the Medical Examiner must be 5821 Queens Chapel Road #146 20782 U.S.A. 14. Race - American Indian. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 GYes 2 □ No If Yes, Give Year or Date 11 n k 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Saltimore, Maryland 21215-0020 Specify: Black Completed by 3 □ Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Postal Service College (1-4or 5+) Years Elementary/Secondary (0-12) 3 Supervisor 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Marian Collins Elmer Ball Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Veronica B. Riggs - Daughter 8000 Glengalen Ln. Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Quantico Cemetery 03/18/04 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee 3821 14th ST, N.W. Wash, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Laminer Due to (or as a consequence of): Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician end for use as the buriel-tren Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1U Y65 3K) No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BS0055918 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Switkes M.D. 31. Dete filed (Month, Day, Year) MAR 1 6 32. Begistrer's Signature State

Registrar

2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09906 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Ц, Imre Bart March 2004 11:25A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Rockville
If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Montgomery Hebrew Home 6. Sex 1 ☐ M 2 ☐ F 8. Date of Birth Apr. 6, 1914 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 89 220-43-6695 Hungary Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1♥ Yes 2 No Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 20815 Hungary 4450 South Park Avenue Apt. 715 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: f Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Manufacturing Hatmaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ernestine Wolfe Siegfried Bart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12204 Seline Way Potomac, MD 20854 Andy Bart-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal Irom State * 4 ☐ Donation 5 ☐ Other (Specify) Garden Of Remembrance 3/14/2004 Clarksburg, MD 21. Signature of Funeral Service Licent 22. Name and Address of Facility Hines-Rinaldi F.H. 11800 New Hampshire Avenue Silver Spring, MD20904 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heathl and Mental Hygiens the properties it items 73 a or 28e-1 show Important: it items 71 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Madical Examinatinant by multiple at Pages 1 and 2 should be filed within 72 hours after death with Baltimore, Maryland 21215-0036 injury or other traumatic event, Physician

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Completed by Funeral

Be 2

the Maryland

/Medical Examiner

burial-transit The law requires that the death certificate be execut attending physician for use as the burlal signed b page 2 certificate To the Hospital or Attending Physicien: within 24 hours after death To the Funerel Director: / completely filled in by the fi

Division of Vital Records, P.O. Box 687

Medical Certification: To Be Completed by Physician/Medical Examiner

Immediate Cause (Final disease or condition	CEREBRAL THROMISO.	515	Onset and Death
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):		
that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of d Month	elivery Day Year
7 -	contributing to death but not resulting in the underlying cause given in Part I. $TENSIBN$	23e. Did tobacco use contribute	to the cause of death? Probably 4 □Unknown
		autopsy prior to	autopsy findings available completion of cause of es 2 \(\sum \) No
25. Was case reterred to medical		h (Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 EP/Outpatient 3 DDA Other: 4 Nursing Ho	me 5 Residence 6 Other (Sp	pecify)
27. Manner of Beath 1 Natural 5 Pending 2 Accident investigati	(Month, Ďaý Year) Injury Work? on M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28f. Location (Street and Number or City or Town, State)	Rural Route Number,
29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex-	Physician: To the best of my knowledge, death occurred at the time, date and place, aminer: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	and due to the cause(s) and manner red at the time, date and place, and d	as stated. ue to the cause(s)

State Registrar 31. Date filed (Month, Day, Year) MAR 1 5 2004

29b. Signature and title of ceftifier

6/21 32. Registrar's Signature

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			5	State of Marylan					d Mental H		e	
			1 - For State Registrar	,	•	rtificat				Reg. N	2001	naan
	Dhysisi		Decedent's Name (First, Middle, Last)						2. Date of D		ay_ Year	3. Time of Death
	Physici /Medio				RAY	,			MARC	H).	5.2004	3:30 8 M
}	Examir	ier	4a. Fecility Name (If not institution, give si			4b. City,		Location of D	Path Day		c. County of Death	·- 0.7)5
	Farment		5. Social Security Number 6. Sex	7. Age (In vrs.		If Under	r 1 Year	If Under 24 h	Hrs. 8. Date of B		PINCE G	leca (State or Foreign
	Funeral Director		213-42-7720		61 Yrs.	Months	Days	Hours N	Hrs. 8. Date of B (Month, D Nov. 1	ay, Yea	7) Cour	fornia
	D ,		Usual Residence of Decedent 10a. State 10b. County	100 68	v. Town or Lo							
	lanyla show	ŏ	Maryland Prince Ge		llege							0d. Inside City Limits 1 Yes 2 No
	28a-1	Director	10e. Street and Number			10f. Zig	o Code			10g. C	itizen of What Cour	ntry?
	172 hours after death with the Maryland *natural; or flems 23a or 28a-f show after Examiner must be notified at		4904 Blackfoot Road	1			2074	0		_	Jnited Sta	*
	ems 2	Funeral	11. Marital Status	Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dece	dent of His	spanic Origin?	? (Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Americ Black, White,	
36	or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 ☐ Yes		Specify:	,		Specify:	White
21215-0036	hour stural	ed b	3 ☐ Widowed 4 ② Divorced 15, Decedent's Educ	Year or Dates:	16a, Dece	dent's Usu	al Occupa	tion		16b	Kind of Business/In	
215	Jwithin 72 ho piene. r than *natur Ire Medical	plet	(Specify only highest grade Elementary/Secondary (0-12)		(Give life.	kind of wo DO NOT u	ork done di ise retired)	uring most of	working	100.		addity
21		Completed	12		Owner	/Oper	ator			Fo	od Servi	ce
Maryland	D E D	Be	17. Father's Name (First, Middle, Last)						Name (First, Middl			
2	should be nd Menta i marked umatic ev	င္	Harry Peter Bra 19a. Informant's Name/Relationship (Typ	_	10b Mailie	an Addrass	Ctroot o		le Marie		Cabanne or Town, State, Zip	Codel
	od 2 Ith a 27 is		Suzanne Werking, si								, Marylar	
re,	of Heal		20a. Method of Disposition		Place of Dispo	sition (Na	me of	1	Date	_	ocation - City or To	
Ē	mit. Pages partment of I cortant: If its injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)						3/19/2004	Ale	xandria,	Virginia
Baltimore,	permit. Pages Department of Important: If I any injury or		21. Signature of Funeral Service License		D 22	2. Name ar	nd Address	s of Facility	dt Funer	al H	lome, P.A.	
	QD E e o		Visual V Bo	was	4	400 P	'owdei	^ Mill	Road Bel	tsvl	le, Maryl	and 20705
			23a. Part1. Enter the disease, or combine shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	n. Do not en	er trie moc	de or dyring	, such as care	ulac of respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Congestive Due to (or as a conseq	Heart	. Fai	lure					
	Examiner		Sequentially list conditions b	Cardiomyop	athy							
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):							
	be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):							
760,	te be ex ysician ye burial	caiE	d	,	,							
89	tificate ig phys as the	edi	u.									
Вох	eath certificat attending phy I for use as the	Physician/M	23b. Was decedent pregnant	c. If yes, outcome of pregna		Ectopic p	regnancy				23d. Date of delive	
о. П	the at	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown		Other (sp			· · · · · · · · · · · · · · · · · · ·		Month	Day Year
<u>~</u>	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th		Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	nderlyina c	ause diver	n in Part I.	23e. Did	tobacco	use contribute to th	ne cause of death?
Records,	uires tha signed l	d by	Ventricular Arrhy		•	,	•			Yes 2		ably 4 Unknown
S	tw requir	Completed							24a. Wa	s an	24b. Were auto	psy findings available
Be	The law ate has page 2:	mo							auto peri 1 ☐ Yes	opsy ormed? 2/2 N	death?	impletion of cause of
Vital	ician: Th certificate ector, pag	Bec	25. Was case referred to medical examiner?					26. Place of 0	Death (Check only		<u> </u>	
of <	Physician: r this certific ral director,	ပ္	1 ☐ Yes 2XX No		ER/Outpatien			4 LI NUISIN			6 □Other (Specif)	()
no	ding F	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	28c. Injury Work'	at ? es 2.⊡No	28d. Describe	how inju	ury occurred	
Division	f or Attending after death, Director: After I in by the fune	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	me, farm, str			2 2 110	28f. Location	(Street a	nd Number or Rura	I Route Number,
ā	s after	Certification:	4 Homicide	building, etc. (Specify	v)				City or To	wn, Stat	'e)	
	To the Hospitel or Attending Physician: within 24 house alter dealth. To the Funeral Director: Albr. completely filled in by the funeral director.	edical (29a. Certifier Certifying Physi (Check only 2 Medicel Examin	cian: To the best of my kno er: On the basis of examina	wledge, death	occurred	at the time	e, date and pla	ace, and due to the	cause(s	s) and manner as st	ated.
	the hin 24	Medi	one) 29b. Signature and title of certifier	and manner stated.			c. License		Journal at the bine			
	₹ <u>8</u> € §		A Continue of Continue			230	D236				ate signed <i>(Month, I</i> March 16,	
	>		30. Name and address of person who con	npleted cause of death (Item	1 23a) (Tyne	Print)						
			Bassant Khandelwa	L, M.D. 1600	Crain	Hwy.,	Gle	n Burn	ie, Maryl	and	21061	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 8 200	32. Registrar's Signa	ture	do	an At	pl				

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:45 A. M March 16, 2004 Raymond Brehm Walter /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Montgomery Village Care and Rehab Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1**X** M 2□ F Ρ́Α Director 86 March 1, 1918 185-03-4564 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Montgomery Village Maryland | Montgomery 10e. Street and Number 10g. Cilizen of What Country? with or Items 23a 19301 Watkins Mill Road USA death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12 Yes 2 No 194
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or lineary injury other traumers. 1942 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 St Divorced 1944 White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) International Elementary/Secondary (0-12) College (1-4or 5+) 5+ Contract Administrator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gertrude Forney ဥ Brehm Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23604 Overlook Park Dr., Clarksburg, MD. 20871 Suzanne A. Maxey/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □Other (Specify) 3-18-2004 Marriottsville, MD. Crestlawn Mem. Park 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral-Service Lice 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition GOITASISZE AIGORDSON **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 5 27313 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): Box 68760. the attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetel death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. F 1 Yes 2 No 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 2 No 1 Yes 2 No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No Medical Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident after death in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H 0051280 March 16, 2004 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Anushiravan Dadgar, M.D., 9715 Medical Center Dr., # 201, Rockville, MD. 20850 31. Date filed (Month, Day, Year) MAR 1 7 2004 32. Registrar's Signature State Registrar

			For State	State of Maryland / Depa	artment of Health and I rtificate of Death		2001	00007
76	Physici /Medio		1. Decedent's Name (First, Middle, La RONALD		imodio oi bodaii	2. Date of Deat Month	og. No. 2 U U 13 h Day Year 6 2004	3. Time of Death 0004 AM
	Examir		4a. Facility Name (If not institution, given BAYVIEW MEN 5. Social Security Number 6. S	e street and number) DICAL CEN TER For Age (In yrs. last birthday)	BALT MO RE If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		4c. County of Death BACTIN 9. Birth Year) 9. Cou	DARE
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Itema 23a or 28a-f show pavent, the Madical Examiner must be nuffied at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number	Point Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give		8 21	0g. Citizen of What Cou	
nd 21215-0036	filed within 72 Hygiene. ther then "na int, the Medic	Be Completed b	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last	College (1-4or 5+) College (1-4or 5+) (Give life.	_	ne (First, Middle, M	16b. Kind of Business/li	e pair
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Heath and Mental Important: If itam 27 is marked o any injury or othar traumatic eve once.	То	19a. Informant's Name/Relationship	20b. Place of Dispocametery, creative for the complete process of the complete	Address (Street and Number or Ru Sollers Poin Scitor (Name of	ral Route Number, It Rd Date 10-04 OCKlea	20c. Location - City or T Lumber + SONF	o Code) 2 cown, State ton Ne uneral Home
8760,	Physician /Medical Examiner Wedical Examiner Physician and Physician and Physician	ai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, baseing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. As piration Sua to (or as a consequence of):				Approximate Interval Between Onset and Death
.O. Box 687	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
S, D	aw requires is been sign 2 should be	Completed by Ph	Part II. Other significant conditions Hepatitis	contributing to death but not resulting in the u	, ,	1 ☐ Ye 24a. Was ar autops	pacco use contribute to us 2 No 3 Pro 24b. Were aut	
on of Vital Record	hyaician: Th his certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes	Hospital: Inpatient 2 ER/Outpatier 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	ot 3 DOA Other: 4 Nursing H	th (Check only one	25No 1 ☐ Yes e) nce 6 ☐ Other (Speci	(fy)
Division	Hospital or Attending P. 14 hours after death. Funaral Diractor: After titely filled in by the funera	I Certification;	3 Suicide 6 Could not to determined	28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	City or Town		
	To the Hospital within 24 hours a To tha Funaral completely fitted	Medical		hysician: To the best of my knowledge, deat miner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur 29c. License number	rred at the time, da	ate and place, and due to be determined as a state and place, and due to be determined. Date signed (Month,	o the cause(s)
12	Sta Regist			32. Registrar's Signature	T 00			

			1 - For State Registrar		ryland / Dep <i>Ce</i>		lealth and M	Mental Hygi	-	
	Physici /Media		1. Decedent's Name (First, Middle, Last, Roger G. Capehar	t				2. Date of Death Month March 14	Day Year , 2004	12:40 P M
	Examir Funeral	er	4a. Fecility Name (If not institution, give Heartland Health 5. Social Security Number 6. Sec	Care Cente	(In yrs. last birthday)	Adelphi	If Under 24 Hrs.	8 Date of Birth	4c. County of De. Prince Ge	
	Director		578-46-7107 Usual Residence of Decedent 10a. State 10b. County	X M 2□F	68 Yrs. 10c. City, Town or Lo		TIOUIS WIIII.	June 9,	1935 Noi	10d. Inside City Limits
	vith the Man	Director	D.C. N/A 10e. Street and Number		Washingt	10f. Zip Code		100	. Citizen of What C	1 ∰Yes 2 No
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amountant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any intry or other traumatic event, the Midlical Examinar must be notified at once.	by Funeral	53:9 Riggs Road, 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	N • L • 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	. 1953-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ▼No	ispanic Origin? (Sp an, Mexican, Puerto Specify:		nited Sta 14. Race - Am Black, Wh Specify:	erican Indian,
21215-0036	within 72 hou iene. Iene. Than "natura Ire Mudical E	ompleted	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+ 2	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Visor Map	during most of work 1)	ring	b. Kind of Business	s/Industry
Maryland 2	nould be filed d Mental Hyg narked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Washington Capeha				18. Mother's Nam Hester	e (First, Middle, Ma Rodgers	iden Sumame)	
re, Ma	s 1 and 2 si f Health and Item 27 ie r gther traur		Jon Proctor (ste 20a. Method of Disposition	epfather)		Riggs Roa	d, N.E.,	al Route Number, C Washing to Date 20		20011
Baltimore,	emit. Page: epartment of portant: If I y injury or		1 🖫 Burial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Mt. Oliv	et Cemete Name and Addres	ry 3/19	0/04 Wa	ashington neral Ser	, D.C.
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ne cause on each line	he death. Do not ent			N.W., Was		Approximate Interval Between Onset and Death
	/Medical Examiner	niner	disease or condition resulting in death) Sequentially list conditions, Tary, leading to minimum districtures. Enter Underlying Cause, Disease or injury.	Dyspha Due to (or as a	consequence of): gia consequence ut):	1				4 days 2 weeks
8/60,	icate be executed physician and s the burial-transit	dical Examiner	Cause (Disease or injury that intiated events resulting in death) Last	Due to (or as a	ovascular consequence of):	accident				2 weeks
O. Box 6	The law requires that the death certifica tte has been signed by the attending ph vage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
ords, P	w requires that been signed to should be det	by	Part II. Other significant conditions con Dementia	tributing to death but	not resulting in the ur	nderlying cause give	en in Part I.		_	o the cause of death?
vital Records,		Completed	Pneumonia					24a. Was an autopsy performed 1 Yes 2 ∑	prior to death?	utopsy findings available completion of cause of
5	ing Phys After Ihis uneral di	atlon: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No H. 27. Manner of Death 1 ☒ Natural 5 ☐ Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work	n: 4X Nursing Ho	me 5 Residence 28d. Describe how		cify)
DIVISION	e Hospital or Attendi 124 hours after death. e Funeral Director: A letely filled in by the fo	Certification;	3 Suicide 6 Could not be 4 Homicide determined	building, etc.			Į.	28f. Location (Stree City or Town, S	tate)	
	To the Hosp within 24 ho To the Func completely fi	Medical	29a. Certifier (Check only one) 1	ician: To the best of her: On the basis of e and manner state	xamination and/or inv	occurred at the time restigation, in my op	inion, death occurr	ed at the time, date	e(s) and manner as and place, and due Date signed (Mont	to the cause(s)
	7		Adura: 30. Name and address of person who cor	mpleted cause of dea	th (Item 23a) (Type I	^ D196			rch 16, 2	
	Sta	te	Raman R. Tuli, M	I.D. 35	03 Perry S	Street, N		er, MD 2	0712	
	Registra	ar 💮	MAR 18 200	4 pener	De la	poorts				

		For State Ragistrar	State of Ma	aryland	/ Depa	rtment of	Health a Death	and M		giene 2 Reg. No.	2004	09909
		Decedent's Name (First, Middle, Last)							2. Date of De.	ath	Year	3. Time of Death
Physicia		Louis Albert Capor	aletti						Month MARCH	1 O	2004	11:12 pm
/Medic Examin	_	4a. Facility Name (If not institution, give str				4b. City, Town,	or Location			4c. C	ounty of Death	
Examin	•	CIVISTA MEDICAL	CENTER	2		LA PI	ATA			CH	ARLES	
Funeral		Social Security Number 6. Sex		e (In yrs. las		If Under 1 Year Months Days		Min,	8. Date of Bird (Month, Qa	h y, Year)	_ Cor	place (State or Foreign intry)
Director		578-42-6131	M 2□ F	76	Yrs.				June 4	, 192	/ Wash	nington, DC
D .	-	Usual Residence of Decedent 10a, State 10b, County		10c, City.	Town or Lo	cation						10d. Inside City Limits
larylan ahow	5			Wald								Y☐ Yes 2☐ No
28a-f	Director	Maryland Charles 10e. Street and Number		Maza		10f, Zip Code			Т	10g. Citize	en of What Cou	untry?
ours after death with the Maryland let's after death with the Maryland Examiner must be motified at										U	SA	
eath	Funeral	2743 Sprague Dr.	2. Was Decedent	Ever in U.S.	. 13. V	2060 Vas Decedent of	Hispanic Or	rigin? (Spe	cify Yes or No	- 14	4. Race - Amer	
ter d	F	1 Never Married 2 Married	Armed Forces? 1 Yes 25	No	11	Yes, specify Cu	ban, Mexica	in, Puerto i	Rican, etc.)	1	Black, White	, etc. nite
urs a	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	I□Yes 2☐No	Specify.	:			Specify: W.I	1116
	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)		16a. Deced	lent's Usual Occu	upation e during mos	st of workii	ng	16b. Kind	d of Business/I	ndustry
	nple	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Pres:	kind of work don OO NOT use retir	red)			A.C.	Tire (Company
filed within Hygiene. other than ent, the We	S	12th			ries.	Luent	40 Mark	ada Nama	/Final Middle	Maidan C		
d oth	Be	17. Father's Name (First, Middle, Last)							(First, Middle		ourname)	
should be nd Mental marked c	٦ م	Alfonso Caporalet			10h Maille	g Address (Stree			Palum!		Tour State 7	in Code)
12 sh h and h and raum		19a. Informant's Name/Relationship (Type Louis Emery Capora		on		Lowery						
permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumatic event, the Manages.		20a. Method of Disposition	Tecci- D	20b. Pla	ce of Dispo	sition (Name of		121	ate		ation - City or 1	
Ary or a first		1 Ø Burial 2 ☐ Cremation 3 ☐ Re	moval from State	-		natory or other pi		00/16	10001	Clin	ton, MD)
d in the P		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses		Kesi		tion Cem			/2004			
permit. Departr Importa		Δ	2 +		HI	NES-RIN	ALDI F	TUNER			leron Cn	20904
NAME OF TAXABLE PARTY.		23a. Part1. Enter the dise, se, or complic shock, or health fire. List only one	ations that caused	d the death.	Do not ent	er the mode of d	HAMPS ying, such as	s cardiac o	or respiratory a	rrest,	ver ap	ring, MD Approximate Interval Between
		shock, or heart allor. List only one Immediate Cause (Final	cause on each li	ne.								Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as		ence of):	erillation	N				-	immediate
Examiner	17		Mode			tec Sta	e de la constante de la consta					EVERGE
≱ ,₹7,	er	Sequentially list conditions, b. cause. Enter Underlying	Due to or as			100 010	10001	-				
uted d ansit	Examiner	Cause (Disease or injury that initiated events c.										
be executed icien and burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of):							
cate be executed physicien and the burial-transit	Physician/Medical	d.										(1) =
leath certifica attending ph	Med	IF FEMALE:	=11100 =2		200	-						
th ce tendii	an/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome 1 ☐ Live birth	of pregnan	death 3	Ectopic pregnar	ncy			23	3d. Date of delification of the contract of th	very Day Year
e dea he at	sici	1 ☐ Yes 2 ☐ No	4 ☐ Pregnant a 9 ☐ Unknown	t time of dea	ath 5□	Other (specify)						
w requires that the death cer been signed by the attendir should be detached for use	Phy	9 Unknown Part II. Other significant conditions confi	ributing to death b	out not result	ting in the u	nderhing cause /	niven in Part	1	23e. Did 1	obacco us	se contribute to	the cause of death?
res ti	by	Partition Significant conductors com	indusing to dedict i	out mot rood.			g		1 🗆	Yes 2	¶No 3 Pro	obably 4 Unknown
requi	Completed									1		taran diadiana available
a law has b e 2 s	nple								24a. Was		prior to death?	topsy findings available completion of cause of
vicion: The lavicertificate has	Cor								1 ☐ Yes	2 No		2 No
iclan sertifi ector	Be	25. Was case referred to medical examiner?	ospital:				Ther		(Check only			
Phys this	-T	1 ☐ Yes 2 🗷 No	1 🗀 Inpati		R/Outpatier 28b. Time o	IL 3L DOA	4 🗀 🛚 🗎		me 5 🗌 Resi 28d. Describe		Other (Spec	erty)
ding After fune	tlon	1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	W	lonk? □Yes 2□			. ,		
deat deat ctor: y the	fica	3 Suicide 6 Could not be	28e. Place of In	jury - At hon	ne, farm, sti	reet, factory, offic	:0		28f. Location (Street and	Number or Ru	ral Route Number,
after Dire	Certification:	4 Homicide	building, e	tc. (Specify))				City or To	wn, State)		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 12 Certifying Phys	icien: To the best	of my know	vledge, deat	h occurred at the	time, date a	and place,	and due to the	cause(s) a	and manner as	stated.
ne Ho n 24 h ne Fu sleteky	edical	(Check only 2 Medical Examin	er: On the basis of and manner st		on and/or in	vestigation, in my	y opinion, de	edin occurr	ed at the time,			
To the withing To the comp	M	29b. Signature and title of certifier	1)	29c. Lice	nse number	r		29d. Date	signed (Month	n, Day, Year)
		1/h H1.	9-	1		Do	0304	84		3	1/12/04	1
7-		30. Name and address of person who col				Print)						
2		CHARLES A. UMOS				BRANC	H AVI	E MAI	RLOW H	EIGH	ITS MD	20748
Sta Registi		31. Date filed (Month, Day, Year) MAR 1 7 2004		rar's Signati	Ly Ly	Spark	21					
ricgisti	للته	MILLION TO LOUR	100		/	//	-					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryla	ind / Depa	artment of I	Health and Death	Mental Hyg	giene 1. g. No. 2	004	09910
	Physici /Medic Examir	cal	4a. Facility Name (If not institution, give s	F. Cav	anah	4b. City, Town, o	or Location of Dea	2. Date of Dea Month March	13, 2	2004 unty of Death	3. Time of Death 1:50a M
	Funeral Director		Shady Grove Adv 5. Social Security Number 186-20-3910 Usual Residence of Decedent		rs. last birthday) Yrs.	Rockvi If Under 1 Year Months Days				9. Birthpi Coun Pitt	ry lace (State or Foreign try) Sburg, PA
	the Maryland 28a-f show notified at	rector	PA. 10b. County Alleghe		City, Town or Lo	burgh			Ing Citizen	of What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
36	172 hours after death with the Maryland *natural*, or ttems 23a or 28a-f show potent Exeminer must be notified at	y Funeral Director	1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		15237		Specify Yes or No- to Rican, etc.)	14.	ISA Race - America Black, White, e	an Indian,
21215-0036	within lene. than	Completed by	3 ☐ Widowed 4 ② Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:		dent's Usual Occup kind of work done DO NOT use retire Educat	pation during most of wo	rking	16b. Kind o	of Business/Ind	lustry h
Maryland 21	should be filed ind Mental Hygi i marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) Garsett Fro 19a. Informant's Name/Relationship (Ty);		10h Maile	Address (Ceres	Paul		fert	У	20006
	es 1 and 2 of Health a item 27 le r other train		Bette L.Cavanah 20a. Method of Disposition 1 🛭 Burial 2 Cremation 3 Re	- daughter	430 Place of Dispo	8 Garre	ett Par	k Road :	Silve 20c. Locatio	er Spr	wn, State
Baltimore,	permit. Pages Department of Important: If it eny injury or o		1 Signature Funeral Service Liounge	į M	PH	Sant Ce	ss of Facility RINALD	I FUNERA	AL SE	RVICE	t Twnshp,
	Physician /Medical Examiner		23a. Pert 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the de e cause on each line. Lung Ca Due to (or as a conse	ncer	41 COLU	IMD1a Bi	c or respiratory arre	er S		, Md 2 0 9 1 0 Approximate Interval Between Onset and Death MO •
8/60,	certificate be executed riding physician and use as the burial-transit	al Examiner	Sequentially list conditions, francisco de la conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse							
O. Box 68/	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)	1			Date of deliver Month	y Day Year
cords, r.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions conf	tributing to death but not re	esulting in the un	derlying cause giv	en in Part I.		pacco use c		e cause of death?
ב ב	The lay ate has page 2	e Completed	25. Was case referred to medical						y ned? ≦ No	b. Were autop: prior to com death? 1 \(\sum \text{Yes} \) 2	sy findings available pletion of cause of
N IO IIO	Phy at d	ToB	examiner?	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Worl	er: 4 🗌 Nursing H	ith (Check only one lome 5 Reside 28d. Describe ho	nce 6 🗆 0		
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	I Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	erfy)			28f. Location (Str City or Town	, State)		
	To the Hos within 24 ho To the Fun completely	Medical	(Check only one) 2 Medical Examination one) 29b. Signature and title of certifier	cian: To the best of my kr er: On the basis of examin and manner stated.	ation and/or inv	estigation, in my of	pinion, death occu	rred at the time, da	te and placed. Date sig	e, and due to t	the cause(s) ay, Year)
	3		30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type, F	Print) Nels	$\frac{1616}{\text{son Kal}}$	77% 6	03-	13-2	004
2,7	Sta Registra	te ar	31. Date filed (Month, Day, Year) MAR 15 200	32. Registrar's Sign	nature 4	Spark		. ,	J .V		

			For State Registrar	. 164	(State of	Marylar		artmen			and M	lental Hy		200	, nc	1911
1	Physicia	an	Decedent's Name				C 1						2. Date of De Month	ath Day		3. Time	of Death
	/Medic		4a. Facility Name (If	Yungke not institution		eet and num		hang	4b. City,	Town, or	Location of	ol Death	March		County of Dea		4 A.
n	Examin		Fox Chase		•			ter	Sil	lver	Spri	ng			Montgo	mery	
	Funeral		5. Social Security No		6. Sex	7	'. Age (In yrs.	last birthday,		1 Year	If Under Hours		8. Date of Bir (Month, Da	th	9. Bi	rthplace (State	e or Foreign
ı	Director		578-78-12		142	A 2□F	81	L Yrs.					June 21	1, 19	22 C	hina	
	and ow		Usuel Residence of 10a. State	10b. County			10c. Ci	ty, Town or L	ocation							10d. Inside	City Limits
	Mary -faho	ţ	MD.	Montgo	omer	V		Bethe	sda							1 🗆 Y	es 2⊠No
	th the	Director	10e. Street and Nun						10f. Zip	Code				10g. Citiz	zen of What C	ountry?	
	23a c	raiD	4521 East	West						0814					ted St		
	er deg	Funerai	11. Marital Status	- 4 - 0.007.14		Armed For		J.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cubar	spanic Ori n, Mexican	gin? (Spi 1, Puerto	ecity Yes or No Rican, etc.))-	14. Race - Am Btack, Wh		
36	rs afte	by F	1 Never Marri Widowed			1 ☐ Yes If Yes, Give Year or Da)		1 ☐ Yes	2 [X No	Specify:				Specify:	sian	
Š	be filed within 72 hours after death with the Maryland all Hygiene. Al	ted	/0	15. Deceden	t's Educa	ition		16a. Dece	dent's Usua kind of wo	Occupa	ation	t of work	ina	16b. Kir	nd of Busines		
215	ithin 7	Completed	Elementary/Secon	ify only highe: ndary (0-12)	si grade i	College (1-	4or 5+)	life.	DO NOT us	se retired,)	or worm	9	_			
2	led will lygier lygier ther th		17. Father's Name ((Eimt Middle	(act)			1	Coo	k	18 Mothe	ar's Name	e (First, Middle		staura Sumame)	nt	
and	d be find He of or a section of	Be c		Unknow		Chang					10. 11.00110	J. 5 . 144.11	Mei	Lin			
Maryland 21215-0036	should to marked marked umatical	은	19a. Informant's Na	•				19b. Mail	ing Address	(Street a	and Numbe	er or Rura	al Route Numb			Zip Code)	
	and 2 ealth a n 27 is		Grace Kad	o/Frier	nd			314 A	rgosy	Dri	ve, G	aith	ersbur	g, MI	2087	8	
ore,	of He of He fitem		20a. Method of Disp 1 X Burial 2 [3	moval from S	- 1	Place of Disp cemetery, cre	osition (Nari ematory or o	ne of ther place	e)	(Date	20c. Lo	cation - City o	r Town, State	
Ĕ	Pages ment of l		`4 □Donation					hingto			-		2004		land,	Maryla	ind
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Begartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury cother traumatic avent, ir a Medical Expriner manable indifficial at Sities.		21. Signature of Fu	Lea	QY.	Lle	Peler	10	2. Name an	Dee	er Pa	rk D	Vol Fun r., Gai	ther			
d	Physician		23a. Part1. Enter the shock, or heat Immediate Cause ((Final			used the dea ich line. nsons			e of dyine	g, such as	cardiac	or respiratory a	rrest,		Approxin Interval E Onset ar	Between
20	/Medical		disease or conditio resulting in death)		(a.		or as a conse		<u> </u>								
	Examiner		Sequentially list co	nditions,	b.	D /											
	ed sit	ine	Sequentially list confirming any, leading to improve cause. Enter Under Cause. (Disease or that initiation are not not that initiation are not not that initiation are not not not not not not not not not not	nmediate rhying -	< −	Due to (d	or as a conse	quence oi):									
^	execut and al-trar	Examiner	that initiated events resulting in death) I	•	C.	Due to (or as a conse	quence of):									
760,	e be executed ysicien and e burial-transit	caiE			d.												
89														-		F	
Вох	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was deceden in the past 12		23	1 Live bi	come of pregn rth 2 Fet	el death 3	□Ect op ic pr					2	23d. Date of d	elivery Day	Year
o.	the at	sici	1 Yes 2	□No	1	4□Pregna 9□ Unkno	ant at time of wn	death 5	Other (sp	ecify)						,	
<u>α</u>	that the ed by detac	, Ph	Part II. Other signif		ons conti	nbuting to de	ath but not re	sulting in the	underlying c	ause give	en in Part I		23e. Did 1	tobacco u	se contribute	to the cause of	of death?
Vital Records,	uires tha signed	Completed by	Diabetes	Melli:	tus '	Гуре І	I,						1 🗆	Yes 2	¶No 3∏F	robably 4	□Unknown
COL	w requir s been si should	lete	Hyperten	sive A	rter	ioscle	rotic	Heart	Diseas	se			24a. Was		24b. Were	utopsy findin	gs available
Re	The lay	шо	Spinal S										auto perfo	ormed?	death?		or cause or
ita		BeC	25. Was case refer examiner?								26. Place	of Deat	h Check on				
	Physician: r this certific ral director,	To	1 ☐ Yes 2 🔀		Ho		npatient 2	_				ursing Ho	me 5□Resi			ecify)	
D C	ing P		27. Manner of Deat 1 X Natural	5 Pendir		28a. Date of (Month	nf Injury n, Day Year)	28b. Time Injury		28c. Injury Work	k?	Na	28d. Describe	how injur	y occurred		
isio	ttand death stor: /	icat	2 Accident 3 Suicide	investi 6 ☐ Could	not be	28e Place	of Injury - At h	nome larm s	M treet_factors		Yes 2□	140	28f. Location (Street and	d Number or i	Rural Route N	lumber,
Division of	l or Al after Direc	Certification:	4 - Homicide	determ	nined		ig, etc. (Spec		troot, ractory	y, 011100			City or To				
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)				sis of examin						and due to the red at the time,				e(s)
	ro the	Me	29b. Signature and	title of certifie	1	1			290	c. License	e number			29d. Dat	e signed (Mor	nth, Day, Year	r)
)	/		Du	utel	9/	1000	ry	2uD		D	13550)		Marc	h 10,	2004	
	5		30. Name and addr	ress of person	who con	npleted cause	e ol death (Ite	om 23a) (Type	. Print)		л ~	100	g 4 1	C	ma 100	2001	0
	Sta	ate	Dr. Berna 31. Date filed (Mon	th, Day, Year,)	32. Pu	egistrar's Sign					,00,	pilver	spr1	ing, MD	. 2091	
	Regist	rar	W	IAR 17	2004		epera	A	1300	uks							

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	ian	DONALD 1. Decedent's Name (First, Middle, Last DONALD	Α.	CLARK	T		2. Date of De Month	Day Y	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of De	MARCI	H 14,200	
Exami	ier	Washington Ad				ma Par			COMERY
Funeral Director		215-34-9837	x 7. A XM 2□ F	Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. (Month, Da		B. Birthplace (State or Foreig Country) Maryland
Se-f show	ector		George	10c. City, Town or Lo	uitland		1		10d. Inside City Limi N☐ Yes 2☐N
la or	ä	10e. Street and Number 3861 St Barn	ahas Ro	ad #T2	10f. Zip Code	746		10g. Citizen of Wh	
anound be more writing for a food a steel deskin with more way your marked other than "netural", or fleme 23s or 28e-f ehow marked other than "netural", or fleme 23s or 28e-f ehow matte event. The Madical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed	12. Was Deceder	nt Ever in U.S. 13. s?		Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		American Indian, White, etc. Black
giene. er than "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4o 4yrs	r 5+) (Give	dent's Usual Occup kind of work done DO NOT use retired rintende	during most of w d)	vorking		ness/Industry nite House cainance)
p = 0 \$	To Be C		Clarke			18. Mother's N Beula		, Maiden Sumame)	
perimit, reges I ariu 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic events.		19a. Informant's Name/Relationship (T. Peggy Ann Will: 20a. Method of Disposition 1 XBurial 2 Cremation 3 Di	iams-si	ster 138	05 Cast osition (Name of matory or other place	le Blvd	Silver	20c. Location - Ci	MD 20903 ity or Town, State
Department Important:		4 Donation 5 Other (Specify, 23. Signature of Funeral Service Licens	1	Jerusale	2. Name and Addre	ss of Facility	Snowden	Funera1	rille, MD Home, PA le, MD 208
hysician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of the disease or condition resulting in death)	a.	is a consequence of):	March 1		/ /	138835	Interval Between Onset and Death
physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of):	HERORY	Uz:	Sent J		
y the attending physician and school for use as the burial-transit	ical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of): ne of pregnancy 2 □ Fetal death 3 [□Ectopic pregnancy □ Other (specify)		Sent 2	23d. Date o	
equires that the death benincate be executed in signed by the attending physician and build be detached for use as the burial-transit.	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	ns a consequence of): ne of pregnancy 2 Fetal death 30 at time of death 50	Ectopic pregnanc,		T .	Month obacco use contribu	Day Year ute to the cause of death?
in a man requires may the attending page 2 should be detached for use as	Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions co	c	ns a consequence of): ne of pregnancy 2 Fetal death 30 at time of death 50	Ectopic pregnanc,	en in Part I.	24a. Was autoperfo	Month obacco use contribu Yes 2 ☑ No 3{ an 24b. We priority dea 21 No 1 □	Day Year ute to the cause of death? Probably 4 Unknow
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This conflicate has been signed by the attending paid director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Medical	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a d	tient 2 ER/Outpatier tient 2 ER/Outpatier giury nay Year) at of my knowledge, deat of examination and/or in	DEctopic pregnancy Other (specify) Inderlying cause give A 28c. Injur Wor M 1 reet, factory, office The occurred at the tire vestigation, in my office The occurred of the contract of t	26. Place of D eer: 4 Nursing y at k? Yes 2 No me, date and pla pinion, death oc	24a. Was autop performed to the performance of the	Month Obacco use contribution Yes 2 MNo 3 (an 24b. We prior deal of the prior de	Day Year ute to the cause of death? Probably 4 Unknow re autopsy findings available to to completion of cause of th? IYes 2 No (Specify) or Rural Route Number,
Attending Figstven. The family equites that the openit certifier at death. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Certification; To Be Completed by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or a d	tient 2 ER/Outpatier tient 2 ER/Outpatier giury nay Year) at of my knowledge, deat of examination and/or in	DEctopic pregnancy Other (specify) Interpolation of the control o	26. Place of D eer: 4 Nursing y at k? Yes 2 No me, date and pla pinion, death oc	24a. Was autop performed to the coursed at the time,	Month Obacco use contribution Yes 2 MNo 3 (an 24b. We prior deal of the prior de	Day Year ute to the cause of death? Probably 4 Unknow re autopsy findings available of to completion of cause of th? I Yes 2 No (Specify) or Rural Route Number, er as stated, if due to the cause(s)

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			For State Registrar	State of Maryland	/ Depa		of He	ealth a		ental Hy	aiene	004	09913
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Rosa Gobl Covau							2. Date of Dea Month March 1	ath		3. Time of Death 8:30 A M
)	Examin		4a. Fecility Name (If not institution, give s Brooke Grove Rehabil 5. Social Security Number 6. Sex	itation & Nursing 7. Age (In yrs. last	birthday)	Sand	y Sp	ring If Under 2 Hours	4 Hrs.	8. Date of Birt	Mon	O Birt	n ry County nplace (State or Foreign untry) rmany
1	Director	_	Usual Residence of Decedent 10a. State 10b. County]M 2∏ F 91	Yrs.		Days	riouis		April 21	, 1912	Ge	10d. Inside City Limits
Baltimore, Maryland 21215-0036	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Maryland Montgomer 10e. Street and Number 6704 Glen Oak Cour 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educing Specify only highest grack [Specify only highest grack Elementary/Secondary (0-12) -12- 17. Father's Name (First, Middle, Last) Johann Gobl 19a. Informant's Name/Relationship (Ty, Rose Marie Cherno 20a. Method of Disposition 1 Burial 2 Cremation 3 Service 21. Signature of Funeral Service License	12. Was Decedent Ever in U.S. Armed Forces? 1	6a. Decede (Give k life. D Cashi c 19b. Mailing 6704 9 of Dispose stery, cremp. Davi i Davi ens Ce	ont's Usual ant's Usual ant's Usual and of work of NOT use er Glen Glen Glen d Mem agony or oth d Mem emete: Name and	Street ar Oak occupate of the original of the original or	Specify: ion 18. Mother Maria Maria Cour 1 Ma of Facility	s Name Sch Tor Rural T Ro Drarch Jef	crity Yes or No-Rican, etc.) rig (First, Middle, nartner Foute Number ockville ate 12, 2004	U.S.A 14. Sp. 16b. Kind of Retai Maiden Sur r. City or To e., Mar 20c. Locati Fal. Funer	Race - Ame Black, White ecity: Ca of Business/ -1 Sal name) wn, State, 2 cyland on - City or 1s Chu	rican Indian, e, etc. ucasian Industry es ip Code) 20855 Town, State
. Box 68760,	death certificate be executed Wedical Examine attending physician and attending physician and attended for use as the burial-transit	Physician/Medical Examiner	23a. Part1. Enter the disease, or comolishock/or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, flany, leading to ammodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Due to (or as a consequent Dy SPH AGLA) Due to (or as a consequent Due to	ce of): Ce of): Ce of):		₹\Z					Date of deliment	Approximate Interval Between Onset and Death Z WEEKS
Records, P.O.	The law requires that the death Ite has been signed by the atter bage 2 should be detached for t	Completed by Phys	9 □ Unknown Part II. Other significent conditions con	9⊡ Unknown	g in the und	derlying cau	use giver	in Part I.		1	es 2 No	o 3 ☐ Pro	the cause of death? bably 4 □Unknown opsy findings available ompletion of cause of
Division of Vital R	Attending Physician: r death. sctor: After this certifica by the funeral director. p	Certification: To Be Con	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	The second second second	Outpatient b. Time of Injury , farm, stree	280 M	Other c. Injury a Work? 1 Ye	4⊠Nurs	sing Hom 2	perfor 1 Yes Check on or ne 5 Resid	med? 2 De No ne ence 6 De now injury oc	death? 1 Yes Other (Spec	2 No
۵	ne Hospital or n 24 hours afte ne Funeral Diru bletely filled in b	Medical Cer	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	ician: To the best of my knowled ler: On the basis of examination and manner stated.	dge, death a and/or inve	occurred at	the time	, date and nion, death	place, ar	nd due to the c	ause/s) and	manner as ce, and due	stated. to the cause(s)
)	To the To the complet	Me	29b. Signature and title of certifier 29b. Signature and title of certifier 30. Name and address of person who co	MD moleted cause of death floor ca	a) (True - 2	D	License				9d. Date sig		Day, Year)
	Sta Registr			154 N. ARTIZAN 32. Registrar's Signature	IST.	,	LIAN	ns for	27,	WD.	2170	75	

			1 - State of Mary State of Mary Registrar AMEND#19 aper INF3/17/04, HW, M	rland / Department	artment of Health a rtificate of Death		rgiene 2004	09914
	Physici	2 D	Decedent's Name (First, Middle, Last)			2. Date of De	eath	3. Time of Death
	/Media		Howard L. Dortch, Sr.		,	March	9, 2004 Yeer	5:00 A M
	Examir	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of	Death	4c. County of Death	1
			11319 Harding Rd. 5. Social Security Number 6. Sex 7. Age (Ir	yrs. last birthday)	Laurel If Under 1 Year If Under 2	4 Hrs. 0 Day -4 Di	Howard	
ĸ.	Funeral Director			39 Yrs. iasi birinday)	Months Days Hours	Min. 8. Date of Bir (Month, Da Sep. 1	ay, Year) 9. Birth Con	nplece (State or Foreign untry)
	*		Usuel Residence of Decedent			sep. 1	, 1914 Ten	nessee
	nylan how		10a. State 10b. County 10	c. City, Town or Lo	ocation			10d. Inside City Limits
	e Ma	cto	Maryland Howard I	aure1				1□Yes 2□No X
	or 26	Dire	10e. Street and Number		10f. Zip Code		10g. Citizen of What Cor	intry?
	ath w	by Funeral Director	11319 Harding Rd.		20723		USA	
	er de Items	nue	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hispanic Origi f Yes, specify Cuban, Mexican,	n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Amer Black, White	
36	rs aft	by F	1 ☐ Never Married		1 ☐ Yes 2 No Specity:			nite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Examitrat must be rediffed at	ed	15. Decedent's Education	16a Dece	dent's Usual Occupation		16b. Kind of Business/l	
2	n n n	Completed	(Specify only highest grade completed)	(Give	kind of work done during most of NOT use retired)	of working	Tob. Kind of Businessyl	ndustry
212	filed with Hygiene. other ther	E O	Elementary/Secondary (0·12) College (1-4or 5+)	F	Intrepreneur		Constructi	on
9	al Hygie other vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother	s Name (First, Middle,	Maiden Sumame)	
<u>a</u>	should be nd Mental marked c	To E	Dudley Dortch		Ludie	Loftin		
Maryland	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street and Number	or Rural Route Numbe	er, City or Town, State, Zi	p Code)
	1 and 2 Health tem 27		Howard L. Dortch, Sr Son	1131	9 Harding Rd, 1	Laurel, MD	20723	
altimore,	S TE TO		20a. Method of Disposition 2 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Ob. Place of Disno	sition (Name of natory or other place)	Date	20c. Location - City or T	own, State
Ē	permit. Pages Department of I Importent: If its any injury or o		`4 □Donation 5 □Other (Specify)	Loudon Pa	ark Crematory03	/10/2004	Baltimore,	MD
Ball	ermit epart nport ny in		21. Signature of Funeral Service Licensee		. Name and Address of Facility			
	707 4 d	1	I shake a will		800 New Hampshi			, MD 20904
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not ente	er the mode of dying, such as ca	ardiac or respiratory ar	rest,	Approximate Interval Between
В	Physician		Immediate Cause (Final disease or condition could in death)	ens	RIS			Sinset and Death
A.	/Medical Examiner		resulting in death) Due to (er as a cou	rsequence of):	0.4			0
	. 1	er	Sequentially list conditions, f any, leading to immediate b. Due to as a col	e de	cubilus	akers		weeks
	pet usit	nlne	Cause (Disease or injury	isequerice oi);	al St			10
	al-tra	Examine	that initiated events resulting in death) Last	rsequence of):	toun	-		month
09/8	icate be executed physician and s the burial-transit	dical		more	- Dem	antea		Med 7.03
9	ificate g phy as the	edic	u.					
ROX	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pr		_		23d. Date of delive	ary
	deati e atte	lcla	in the past 12 months? 1 ☐ Yes 2 ☐ No.		Ectopic pregnancy Other (specify)		Month	Day Year
j.	at the de by the a	hys	9 ☐ Unknown 9 ☐ Unknown					
s,	~ 60	by F	Part II. Other significant conditions contributing to death but not	resulting in the un	derlying cause given in Part I.	23e. Did to	bacco use contribute to t	he cause of death?
2	w requires been signe should be		1017 / Bu			1□Y	es 2 12 No 3 □ Prot	oably 4 Unknown
ecor	law as b 2 sl	ompleted	Cardlae Mumu	r		24a, Was a		psy findings available
<u> </u>	Th ate pag	CO				autops	med? death?	mpletion of cause of
VII	i iii	Be	25. Was case referred to medical examiner?		26. Place of	Death (Check only or		
0	this all dir	2		2 ER/Outpatient	3□ DOA Other: 4□ Nursi	ng Home 5 L side	ence 6 Other (Specif	y)
	ding Ph h. After th funeral	ertification:	27. Manne Death 1 atural 5 ☐ Pending 28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	28c. Injury at Work?	28d. Describe he	ow injury occurred	
Sion	teat tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
	or Atten after deat Director; I in by the	E	4 Homicide determined 28e. Place of Injury - 1	At home, farm, stre <i>ecify)</i>	et, factory, office	28f. Location (Si City or Town	treet and Number or Rura n, State)	al Route Number,
	pital purs a erel l	O	29a. Certifier 1[Certifying Physicien: To the best of my	lana cola de la decenia		1		(b)
	To the Hospital or Al within 24 hours after or To the Funerel Directompletely filled in by	edical	29a. Certifier 1 Toertifying Physicien: To the best of my (Check only one) 2 Medicel Exeminer: On the basis of exam and manner spates#	nination and/or inv	occurred at the time, date and pestigation, in my opinion, death o	place, and due to the ca occurred at the time, d	ause(s) and manner as si late and place, and due to	tated. the cause(s)
	omplk	Me	29b. Signature and the of certifier	,	290. License number		9d. Date signed (Month)	/
	- 5 - 6		Vilan Tillers	MU)	1)08(3/	[フラー	2/9/	((
-	7	-	30. Name and address of person who completed cause of death	Item 23a) (Type 5	Stefan A E	tgrowh, M.	0/1/0	7
			4794 Beaver	SKING	921 6/1	mhr.	MID 9	1044
	Stat	е	31. Date filed (Month, Day, Year) 32. Begistrar's S		1-4 -00	10 down	1-00 2	
	Registra	r	MAR 11 2004 Some	19	Sports/			

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State of Maryland	Department of He	ealth and Me	ntal Hygiene	200	į

For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** February 15, 2004 3:45 P M Clara Gerone Duren /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Charles Civista Medical Center LaPlata | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | Month Day, Year | Dec. 14, 1917 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 💹 F 577-30-8601 86 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rat, or items 23a or 28a-f show Examiner must be collified at 1 ☐ Yes 2 XNo Maryland | Charles Brandywine Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 16035 Woodville Road 20613 U.S.A. Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify: by 3 ₩idowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stella Brown Zester Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gerone Duren/Son 16035 Woodville Rd., Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X☐ Buriaf 2 ☐ Cremation 3 Removal from State Fort Lincoln Cemetery2-21-2004 Brentwood, Maryland 4 □ Donation 5 Other (Specify) 22. Name and Address of Facility
Fort Lincoln Funeral Home
20.722 21. Signature of Funeral Seg 3401 Bladensburg Rd., Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure **Physician** /Medical Due to (or as a consequence of) **Examiner** Brain Damage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Seizure Disorder The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕅 No 4☐Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No has page 2 certificate 1 Yes or Attanding Physician: director 25. Was case referred to medical 26. Place of Death (Check only one, Be Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1X Natural 5 Pending 1 Yes 2 No death. investigation 2 ☐ Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel within 24 hours a To the Funerel I 1 Acartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe D-02975 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.11345 Pembrooke Sq. #104 Waldorf, MD 20603 Daniel M. Howell, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 2 2004 Registrar

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		For State Registrar	State of I	Maryland	d / Depa <i>Cer</i>	irtment of F tificate of	lealth and Death	Mental Hy	giene Reg. No	2004	09916	
Physicia /Medic		1. Decedent's Name (First, Middle, La Richard Andrew De						2. Date of De Month March		2004 Year	3. Time of Death 8:30 A. M	
Examin		4a. Facility Name (If not institution, given Holy Cross Hospit		er)		4b. City, Town, o	r Location of Dea Spring	th		County of Death	7	
Funeral Director		213-58-8820	Sex 7. 1⊠M 2□F	Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year, 9, 1	9. Birthp Cour 952 New	place (State or Foreign htry) York	
Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Marry Land Marris on		1	Town or Lo					1	10d. Inside City Limits 1 ☐ Yes 2 🛂 No	
with the Page or 28a-	Il Director	Maryland Montgor 10e. Street and Number 9508 E. Bexhill I		Ken	singto	10f. Zip Code 20895			10g. Ci	tizen of What Cour	ntry?	
In any state of the first of th	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Movinored	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? [͡x]No	It	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		14. Race - Americ Black, White, Specify: White	etc.	
within 72 hou lene. than natura	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0·12)		or 5+)	life. L	ent's Usual Occup kind of work done 10 NOT use retired Analyst	ation during most of wo	rking		lecommuni	dustry	
td be filed ental Hygi ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last)				Marysc		me (First, Middle	, <i>Maid</i> er		cations	
and 2 shou eaith and M m 27 is mar her traumat		19a. Informant's Name/Relationship	_(Туре, Print) Father				and Number or R	ural Route Numb	er, City	or Town, State, Zip		
permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and injury or other trauence.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from Sta	ate ce	ace of Dispos metery, crem	sition (Name of patory or other place	(a) March	Date 2004	20c. L	ocation - City or To		
permit. Departmine Importa any inju		21. Signature of Funeral Service Lice	nsa Suf)	Fr	Name and Addre	ss of Facility Collins	Funeral	Hon			
Physician /Medical		23a. Part1. Enter the disease, or conshock, or high failur. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	h line.	Do not ente						Approximate Interval Between Onset and Death	
Examiner tissue	Examiner	Sequentially list conditions, frank, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
ate be hysici the bu	dical Exa	resulting in death) Last Due to (or as a consequence of): Hepatitis C Infection										
2 = 2	Physician/Me										ory Day Year	
quires that an signed b	þ	Part II, Other significant conditions	contributing to deat	h but not resul	ting in the un	derlying cause give	en in Part I.			use contribute to th	ne cause of death?	
The law recate has been page 2 sho	Completed							24a. Was autoj perfo		prior to con death?	psy findings available inpletion of cause of	
hysician this certifi al director	To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	Hospital: 1 🕱 Inpa		R/Outpatient	3□ DOA Oth	er: 4 🗌 Nursing H		dence	6 ☐Other (Specify	1)	
tending F death. tor: After the funer	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	n 18 200 Bloom of	Day Year)	28b. Time of Injury		/ at <br Yes 2 □ No	28d. Describe				
pital or A	Certif	4 Homicide determined	building,	etc. (Specify)		et, factory, office	4-1	City or To	wn, State			
o the Hos ithin 24 ho o the Fun ompletely t	Medical	(Check only one) 2 Medical Exer	nysicien: To the be miner: On the basis and manner	s of examination	neage, death on and/or inv	estigation, in my of	oinion, death occu	rred at the time,	date and	and manner as sta d place, and due to te signed (Month, L	the cause(s)	
10		30. Name and address of person who	D Ma	Olde	23a) (Type 5	D D	005615	3	3	7/04		
Stat	·e.	Kristie D. Nowak, 31. Date filed (Month, Day, Year)	M.D.,	3110 G1	cacefi		Silver	Spring,	Mar	yland 20	904	
Registra		MAR 08 20	04 1	war	19	Sparks						

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State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Mee Wai Der March 11, 2004 12:20 PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner Rockville if Under 24 Hrs. | 8 Casey House Montgomery If Under 1 Year 6. Sex 7. Age (In yrs. lest birthdey) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** Min Months Days Hours 1□ M 201 F Yrs. 91 Director Jun 28, 1912 China 212-74-5869 Usual Residence of Decedent filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or frems 23s or 28e-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2/☐ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20904 13440 Bregman Rd Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 Divorced Asian 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be flied Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic eventions. Be Yip Jun Cheung Mui Chan 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) Bing N. Der/Son 13440 Bregman Rd, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Ь 4 ☐ Donation 5 ☐ Other (Specify) Mar 13, 2004 Adelphi, MD George Washington Cem 22. Name and Address of Facility Hines-Rinaldi Funeral Home 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave, Silver Spring, MD 20904 Nancy 23a. Part1. Enter the dish se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat for ure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Intracranial Bleed Examiner Due to (or es e consequence of): Examine physician and the buriel-trensit or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): use as t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Dementia þ 9 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Be Completed page 2 should performed Subdural Hematoma 1 ☐ Yes 2 ☐ No TILLY SE ZIXNO 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6XOther (Specify) Certification: To 1 X Yes 2 □ No Hospice 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours efter death.

Per Funeral Director: After the full of the 1 ☐ Yes 2 ☑ No Unknown [™] investigation Unknown 2 Accident 3 Suicide Probable Fall 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Unknown Unknown To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated. Medical within 24 hou To the Funel completely fi (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 10ms/20 March 11, 2004 D51916 atucia 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Patricia Tomsko Nay 6121 Montrose Rd, Rockville, MD 20852

Registrar

State

31. Date filed (Month, Day, Year) MAR 1 7

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32. Registrar's Signature

		State Registrar 1. Decedent's Name (First, Middle, Last,		Ce	rtificate o	Dealli	2. Date of Dea		3. Time of Death		
ysicia		LINA	DINERSTEIN	1			MARCH 9	,	2:40_A		
Medic amin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of Deatl	h	4c. County of C	Death		
Ξ.,		SUBURBAN HOSPITAL			BETHESI		O Date of Bird	MONTGOM			
eral ctor		052-09-2821	7. Age (In yrs.)	Yrs.	Months Day		8. Date of Birth (Month, Day 10/10/1	Year) 1907 A	Birthplace (State or Fore Country) USTRIA		
1		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Li	ocation			10d. lr			
alifie	Director	MARYLAND MONTGOME	RY KENS	SINGTO	7			10g. Citizen of Wha	1 X Yes 2 □		
Den		10e. Street and Number 3620 LITTLEDALE RO	DAD.		10f. Zip Cod 2089			U.S.A.	(Country :		
A SAME	Funerai	11. Marital Status	12. Was Decedent Ever in U.	S. 13.		of Hispanic Origin? (S Juban, Mexican, Puert			American Indian,		
aumatic event, the Medical Examiner rount be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 I		o rican, etc.)	Specify:	White, etc. WHITE		
dical	Completed	15. Decedent's Edu (Specify only highest grad		(Give	edent's Usual Oc s kind of work do DO NOT use rei	ne during most of wor	rking	16b. Kind of Busin	ess/Industry		
De Me	duc	Elementary/Secondary (0-12)	College (1-4or 5+)	HOMEM		(1190)		OWN HOME	7		
ent, Il	0	17. Father's Name (First, Middle, Last)		HOPLE	AKLK	18. Mother's Nar	me (First, Middle,	Maiden Surname)			
lic ev	To B	ISAAC	ZEICHNER			HELEN		ZEICH	INER		
umal		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Maili	ing Address (Str	eet and Number or Ru	ıral Route Numbe	er, City or Town, Sta	te, Zip Code)		
er tra		SIDNEY DINERSTEIN		-		DDS DR., N					
Ogo Too		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☒ F	lemoval from State	emetery, cre	osition (Name of ematory or other	place)	Date	20c. Location - City			
nux		* 4 Donation 5 □ Other (Specify)	RIV		CEMETE		1/2004	SADDLEBRO	OOK, NJ		
any in ury or other traumatic once.		21. Signature of Funeral Service Licens	udeure	D 1	170 ROC	Y-GOLDBERG KVILLE PIK	E, ROCKV	ILLE, MD	5, INC. 20852		
		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	cations that caused the deat ne cause on each line.	h. Do not en	iter the mode of	dying, such as cardiad	or respiratory ar	rest,	Approximate Interval Between Onset and Deat		
cian		Immediate Cause (Final disease or condition	PULMONARY E	MBOLUS					10 HOURS		
dical iner		resulting in death)	Due to (or as a conseq	uence of):					2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		
	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):					4 MTEY2		
insit	Examiner	Cause (Disease or injury									
e burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):							
the bur	cai		d								
for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna			-		23d. Date o	f delivery		
ed for t	Physician/Medi	n the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown		□Ectopic pregna □ Other (specify			Month	Day Year		
detach	Phy	Part II. Other significant conditions co	ntributing to death but not res	ulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribu	ite to the cause of death		
should be detached	d by						101	/es 2∑No 3[☐ Probably 4 ☐Unkn		
shou	iete						24a. Was	an 24b. Wer	re autopsy findings avail r to completion of cause		
age 2	Completed						autop perfo 1 Yes	rmed? dea	r to completion of cause th? Yes 2☐ No		
director, page	0	25. Was case referred to medical				26. Place of De	ath (Check only o				
al direc	To B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatient 2	ER/Outpatie	ent 3 DOA	Other: 4 Nursing H	dome 5 ☐ Resid	dence 6 Other (Specify)		
funera		27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njury at Work? 1 □ Yes 2 □ No	28d. Describe I	now injury occurred			
completely filled in by the funeral	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, s fy)	treet, factory, off	ice	28f. Location (S City or Tox		or Rural Route Number,		
tely filled	edicai Co		vsician: To the best of my knot iner: On the basis of examination and manner stated.								
eldmo	Med	29b. Signature and little of certifier	and marinor stated.		29c. Lic	ense number		29d. Date signed (A	Month, Day, Year)		
28		> Millsom			Do	060167	-	MARCH 9,	2004		
v		30. Name and address of person who d	ompleted cause of death (Iter	п 23а) (Туре		- 0010-1		IMMOII 9,	~•UU- T		

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			for State Registra MEND#10 open FH3/	State of Maryland /		rtment of H			giene Reg. No. 2 (004	09919	
H	Physicia	an	Decedent's Name (First, Middle, Last)	10/04, BM, MCC		Elia		2. Date of Dea Month Q v C	ıth	200'H	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give st			4b. City, Town, or				ty of Deeth		
	·	C1	Shady Grove Adve	entist Hospital		Gaithers				gomer	-	
	Funeral Director		5. Social Security Number 6. Sex 1□	M 2 F 87	Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1916		lece (Stete or Foreign http) XAS	
	and and	}	Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation GERMA	NTOWN			1	0d. Inside City Limits	
	Mary I sho	tor	Maryland Montgome:			Germant		1 ☐ Yes 2X No				
	or 28s	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Country?			
	s 23a	ral	21000 Father Hu	rley Blvd. 2. Was Decedent Ever in U.S.	12 1	20874 Vas Decedent of H			U.S.A.			
' 0	fter de r Itam ilner r	Funeral	11. Marital Status 1 Never Married 2 Married 1	Armed Forces? 1 ☐ Yes 2 ☑ No	l It	Yes, specify Cuba	in, Mexican, Pue	rto Rican, etc.)	BI	ack, White,	etc.	
903	n 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f show valcal Exballier must be notillied at	b	3 Widowed 4 Divorced	Year or Dates:		X Yes 2□ No		exican	Spec		ite	
15-0	- 3	lete	15. Decedent's Educ (Specify only highest grade	ation 16 completed)	(Give	lent's Usual Occup kind of work done of OO NOT use retired	during most of w	orking	16b. Kind of		•	
21215-0036	d within giene. ir then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Pers	sonal			Natio	nal Pa	ark Service	
D	ould be filed a Mental Hygie arked other latic avent, II	Be	17. Father's Name (First, Middle, Last) Felix Balboa H	ernandez			18. Mother's N	ame (First, Middle, Apolonia		-		
aryl	should and Me a mark umati	2	19a. Informant's Name/Relationship (Typ		9b. Mailin	g Address (Street	and Number or I	Rural Route Numbe	r, City or Town	n, State, Zip	Code)	
Ž,	and 2 eaith a m 27 in		Dina Bushrod / Da					Cheverly,		0785	Chate	
Baltimore,	permit. Peges 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked any injury or other traumatic a gncs.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	movai from State		sition (Name of natory or other place			20c. Location			
ıltin	artmen ortant injury		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Paryice License		22	pe Cemete . Name and Addre	ss of Facility J	3/2004 oseph Gaw	Del R Ters	Sons,	Inc.	
B	Dep of the control of		> Aldm	1000 ·	5	l30 Wisco	nsin Av	enue, N.W	• WDC	2001	6	
E			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death. Decause on each line.	o not ente	er the mode of dyin	g, such as cardi	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Intra Chanic	l.	bleed						
7	Examiner			hypertension	ce or).							
	D E	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):							
	xecute and II-trans	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	ce of):							
8760,	ate be executed hysicien and the burial-transit		U ₀									
9	dificate ng phys	Medi	IF FEMALE:									
Box	seath certifica attending ph for use as th	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death	ath 3	Ectopic pregnancy Other (specify)	,			ate of delive fonth	ery Day Year	
O.	t the de by the a	nysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	, 3	(Specify)						
<u>a</u>	es tha igned be de	þ	Part II. Other significant conditions con	inbuting to death but not resulting	g in the ur	nderlying cause giv	en in Part I.		obacco use co ′es 2 □ No	ntribute to th	ne cause of death?	
Records,	w requires been si	Completed						24a. Was	an 24b	. Were auto	psy findings available mpletion of cause of	
l Re		mo:						autop perfor	med? 2 2 No	death?	2 No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth		eath (Check only o				
of	Physic rthis ral dir): To	1 ☐ Yes 2 ☑ No 17	28a. Date of Injury 28t	Outpatien b. Time of	1 3 DOX	- Linuising	Home 5 Resid			y)	
ion	Attending Fir death. ector; After by the funer	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yeer)	Injury		k? Yes 2 □ No					
Division	after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (5 City or Tox		nber or Rura	il Route Number,	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier LCertifying Phys (Check only one) 2 Medical Examin	Ician: To the best of my knowled er: On the basis of examination and manner stated.	dge, death and/or in	n occurred at the tire vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the courred at the time,	cause(s) and n date and place	nanner as s o, and due to	tated. o the cause(s)	
	within 2 To the Comple	Mec	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ed (Month,	Dey, Year)	
	1		Leoshio	M.D		06	0557	1	larch '	8 th.	2004	
	1>		30. Name and address of person who co			Print)						
	St	ate	Leo L. Shue, M.D. 31. Date filed (Month, Day, Year)	 Registrar's Signature 	venti			kville, N	1D 208	50		
	Regist		MAR 1 6 200	4 America	D	sporks	A. C. C. C. C. C. C. C. C. C. C. C. C. C.					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year **Physician** 2004 3:30AM AVIO /Medical 4b. City, Town, or Location of Deeth Facility Name (If not institution, give street end number) 4c. County of Deeth Examiner TMURE CAL Ltimor If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10XM 2□ F Director 234-56-4241 65 August 22,1938 Georgia Usuel Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f shov if Haalth and Mantal Hygiene. Item 27 Is marked other than "natural", or Hams 23s or 28s-f eho other traumstic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Washington Sharpsburg 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Funerai 18609 Mt. Lockhill Road 21782 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1957— Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0020 Specify Specify: ģ 3 2 Widowed 4 □ Divorced Year or Dates 1963 Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Iron Worker Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Jefferson Ellis Dorothy Pauline Culberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dapartment of Haalth a Important: If Item 27 Is any injury or other tra-Chris Lee Ellis / Son 18609 Mt. Lockhill Road, Sharpsburg MD 21782 20a. Method of Disposition
1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2004 Waynesboro, VA Augusta Crematory 21. Signature of Funeral Service-L 22. Name and Address of Facility Turner Robertshaw Funeral Home M00956 1200 N. Shenandoah Ave., Front Royal VA 22630 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Physician Immediate Cause (Final disease or condition resulting in death) /Medical 2 10425 Examiner Physician/Medical Examiner attanding physician and for usa as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ata has been signed by the page 2 should be datached 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 200No 1LI Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To this : After this 28c. 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: At completely filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) William Werchandy 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) ION 31. Dete filed (Month, Day, Year) Begistrer's Signature State outo Registrar

13456 42H

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** March 11, 2004 1:55 A Anna Erdman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5904 Kingsford Place Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Y Dec. 28, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 2√2F 1945 New Jersey 578-60-2544 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other reaumatic avent. The Wedical Event are must be recitified... Once. 1□Yes 2□No Bethesda Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 USA 5904 Kingsford Place Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: þ White 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Pediatrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marta Wankowicz Jan Erdman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elias Walendowski-Son 5904 Kingsford Place Bethesda, MD 20817 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Lincoln Crematory 03/12/2004 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home Funeral Service Licepses 1800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 9 Months Immediate Cause (Final **Physician** disease or condition resulting in death) Metastatic Ovarian Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Box 68760, Physiclan/Medical the as IF FEMALE: 987 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2□ No 1 Yes 2 X No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2 XNo Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the base of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0033793 March 11, 2004 30. Name and address of serson who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Ave. Suite 1300 Chevy Chase, MD 20815 Frederick Smith, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 15 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Physician March 13, 2004 Estelle Hilda ESENSTAD 4:10 PM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Montgomery Hospice Rockville Montgomery 8. Date of Birth (Month, Day, Year) Feb. 27, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1□ M 2□ F Days Hours Director 577-12-4925 84 Maryland Usual Residence of Decedent pernit. Pagas 1 end 2 should be filed within 72 hours after death with the Maryland Depertmant of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at Director 1 ☐ Yes 2√☐ No Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1121 University Blvd., W #1215 20902 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Stetus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🕅 No Specity: Š Specify: white 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Buyer Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Hyman Tabb Celia Becker 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 20902 19e. Informant's Name/Relationship (Type, Print) Ann Cohn, Sister 1121 University Blvd., W #1215, Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Adas Israel Congregation Cemetery Washington, DC 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun and Service Licensee Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St., NW, Washington, DC 20012 23a. Pent1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Alzheimer's Disease Years Examiner Due to (or es a consequence of) by Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the bunal-tran Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown <u>Aspiration</u> Pneumonia Completed Be Certification: To

To the Hospital or Attending Physician: The lew requires that the daath certificate be axecuted Division of Vital Records, P.O. Box 68760, within 24 hours aftar death.

To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be datached

				24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2X☐ No	1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)	
1 ☐ Yes 2 💢 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 10th	er (Specify) Hospice
7. Menner of Deeth 1 IX Naturel 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At h building, etc. (Specia	ome, farm, street, fac	28f. Location (Street and Numb City or Town, State)	er or Rural Route Number,	
29a. Certifier 1	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and plac ion, in my opinion, death occ	ce, and due to the cause(s) and ma curred at the time, date and place,	nner as stated. and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

29c. License number

DO 9470

29d. Date signed (Month, Day, Year)

March 14, 2004

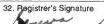
M D 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

10400 Connecticut Ave. #606, Kensington, MD Eugene P. Libre, M.D.

State Registrar

edicai

31. Date filed (Month, Day, Year) MAR 1 5 2004



State of Maryland / Department of Health and Mental Hygiene 0 0 4 Registrar State Amend Item 5 per FH,G830,04/05/04dhb Certificate of Death 09923 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 March 10, 12:30 A Lloyd Stanley Fultz /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Cecil Sun Bridge Nursing Home Elkton If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 52Social/Security Number 234-42-9704 232-42-9704 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1X M 2□ F 73 Yrs. 1930 West Virginia May 12, Director Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a f show minior or other traumatic event, the Modical Examinat must be routified at sine. 1X Yes 2 No Directo WVHardy Moorefield 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 207 Town Run Road 26836 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No 1948 If Yes, Give Year of Dates: 1949 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 TN No Baltimore, Maryland 21215-0036 Specify: δ 3 Widowed 4 Divorced 1949 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian County Government 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Annie Belle Weatherholtz Gus Fultz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1974 Welton Orchard Rd., Petersburg, WV 26847 Eileen Hose (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Fultz Family Cemetery 3/13/04 Kessel, WV 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Fraley Funeral Home 145 N. Main St., Moorefield, WV muce 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical anding p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t autopsy performed? 1 🗌 Yes 2L No or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No this After th funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the f Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 4 | Homicide within 24 hours a To the Funeral I To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 3/10/0 2 30. Name and address of person who completed cause of death (Negr 23a) (Type, Pri S. UNION al 6 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 17 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Day 2004 Month **Physician** MARCH 13, 7:25 A ROSE C. GALVIN /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUMMERVILLE AT POTOMAC POTOMAC If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthpface (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Hours 1□ M 2□€ Yrs. POLAND JULY 4, 1904 578-62-1838 99 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 No DC WASHINGTON Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20015 U.S.A. 3222 NORTHAMPTON STREET, N.W. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ges 1 and 2 should be filed within 72 hours after it of Health and Mental Hygiene. If item 27 is marked other then "netural", or Ite 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: δ 3 □ Widowed 4 □ Divorced WHITE Completed the Muzical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) TEACHER PUBLIC SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IDA GLUCOFT MAX COHEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 OVERPOND COURT, POTOMAC, MARYLAND MERLE N. CANTOR/DAUGHTER other MARCH 14 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 Burial 2 □ Cremation 3 Removal from State permit. Page Department of Important: If any injury or 2004 FALLS CHURCH, VIRGINIA * 4 ☐Donation 5 ☐ Other (Specify) KING DAVID MEML GDNS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. MARYLAND 20852 1091 ROCKVILLE PIKE, ROCKVILLE, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of) **Examiner** b. AORTIC STENOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed the attending physician and the dr use as the burial-transit Exami Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 99 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ANEMIA page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEMENTIA autopsy performed? this certificate 1□ Yes 2√2 No 1 ☐ Yes 2 No HEARING LOSS or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) ASSISTED Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) LIVING 1 ☐ Yes 2 X No Medical Certification: To 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 T Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43254 Course M. Û MARCH 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EXECUTIVE BLVD, ROCKVILLE, MARYLAND 20852 COSGROVE, MD 6111 LAURENE E. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 racks 5

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item #2, per DVR, G830, 4/1/2004 pand / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Year **Physician** Ethan Grove 9:30 P. M 24 2003 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin

H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Days Hours Min. | March 3 1930 Worcester Atlantic General Hospital 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 15€M 2□F Yrs Penna. 215-26-8195 74 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Berlin Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21811 2 Sassafras Lane or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Roofing 11 . Pages 1 and 2 should be filed w trent of Health and Mental Hygier tant: If Item 27 is marked other ti jury or other traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Almeda Landis John Franklin Grove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Sassafras Lane Berlin, Md. 21811 Patricia Grove/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 3/29/04 Rest Haven Cemetery Hagerstown, Md. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 21. Signature of Funeral Service Licensee 17225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician wer whe lining /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): by Physician/Medical The law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has 1 ☐ Yes 2 ☑ No 2 □No 1 Yes 215 Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification; To o 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation Division 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 125/04 HU53714 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -1. MATZONE Bencia, MO 21811 Healthway DRIVE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** GAULDIN Jacqueline March 11. 2004 2:50 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Laytonsville 8601 Plum Creek Drive Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🖫 F Vrs Washington, DC Director 215-38-6034 28, 1939 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "neturel", or Items 23e or 28e-4 show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Virginia Prince Edward Rice 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2485 Lockett Road 23966 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter I Department of Health and Mental Hygiene. Important if item 27 is marked other than "neturel", or ite any injury or other traumatic event, the Medical Examina 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Nurse Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul W. Burdette Nettie Griffith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8601 Plum Creek Drive, Laytonsville, MD 20882 Jean Rodberg, Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/12/04 Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Torchinsky Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part I Eprer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the e Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed Hospital or Attending Physician:
 24 hours efter death.
 Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 5 Residence 6 VOther (Specify) examiner? N☐ Yes _2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Certification: To To the Hospital or Attending Phys within 24 hours efter death.

To the Funerel Director: After this completely filled in by the funeral dir 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated 29s Catflet edical (Check only one) 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Montrose Road, Rockville, MD 20852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 6/2 attricia

32. Registrar's Signature

Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)

MAR 1 5 2004

		1	For State of M	aryland		artment of tificate of		ind Me		giene Reg. No.	200	L	09928					
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	/Medica	al -	Ruby Barnelle Giroux la. Facility Name (If not institution, give street and number,			4b. City, Town,	or Location o		March		2004 County of D	eath	4:05 PM					
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F. OSpm Baltimo	permit Departn Imports any inju		21. Signature of Funeral Service Licensee	Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Shock, or heart failure. List only one cause on each line.														
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			30 Name and address of person who completed cause of 1887 B. Sherry M.D.	death (Item		Print) YYUYA	Dr.	N	Theato	ή,	mp	20	906					
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			For State Registrar	State of Marylan		artment of H			giene Reg. No.	2004	19931
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O At	iract iract n by	ertification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str (y)	reet, factory, office		City or Tow		Number or Rura	I Houte Number,
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9	the splan	Medical	one)	and manner stated.		29c. Licens	a number		29d Date	signed (Month	Day Year)
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7		1	30. Name and address of person who	4	n 23a) (Type,	Print)	m 11/1	1055 2	0.7		71707
			Andrew Amstrong		uno it	ospital 60	U IV. WO	ire si. Ba	etim	one mi	0 61257
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 6 21	32. Registrar's Signa	B	Spark	21				

State of Maryland / Department of Health and Mental Hygiene 🥎 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 March 13, **Physician** Arthur Karl Groh1 6:40 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3367 S. Leisure World Blvd, #2 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1XM 2□F Yrs. 220-06-3626 100 Aug 5, 1903 Director Germany Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County rthan "natural", or Items 23s or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with Germany 3367 S. Leisure World Blvd, #2 20906 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: à 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Mechanical Engineering 12 permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Importent: If item 27 is marked other th
any injury or other treumatic avant. In
once. othert 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Groh1 Auguste Meifert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) 20906 Edeltraud Grohl / Wife 3367 S. Leisure World Blvd, #2. Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Metropolitan Crematory Mar 14 2004 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFrancis J. Collins Funeral Home, Inc Kei Stiles 500 University Blvd, West, Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Two Days **Physician** Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien: The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Rheumatoid Arthritis Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? res 2 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 🖺 Natural 5 Pending investigation s after decreal Director: Alt 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel within 24 hours at To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number Willand a Westerman. D52451 March 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville Pike, Suite 103, Rockville, MD 20852 Michael Westerman M.D. 31. Date filed (Month, Day, Year) MAR 1 6 2004 32. Registrar's Signature souls Registrar

State of Maryland / Department of Health and Mental Hygiene ? 0 1

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e G	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. If Health and Mental Hyglene. Itiem 27 is marked other than "netural", or items 23s or 28s-f show other traumatic event, ire Medical Examinat install by inalified at		Denise Mo		daugnte	Г	20b. PI				her Way,	Date				155U own, State	
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$\widetilde{\bigcirc}$	permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nn any injury or other traumetic event, the Medl once.	d c	21. Signature of Po	Allera Service Lit	2011300		MOO	000	106	T	ress of Facility K	eeney ar	nd Ba	asfor	d Fu	neral	
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) 2004 Year **Physician** MARCH 28, 5:00 a. GRACE EVELYN HANKEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** EMMITSBURG, FREDERICK 17626 MT. VIEW RD. If Under 1 Year If Under 24 Hrs.
Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year, SEP . 25, 1 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F 1933 THURMONT, MD. 70 214-28-7276 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Items 23a or 28a-f show the Mudical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director FREDERICK EMMITSBURG MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21727 17626 MT. VIEW RD. U.S.A. death 1 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 ☐ Divorced *natural Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BOARD OF al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) EDUCATION FOOD SERVICE & CUSTODIAL 6 event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CATHERINE RIDENOUR CHARLES RHODES 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EMMITSBURG, MD. 21727 STEPHEN G. HANKEY/SON 17627 MT. VIEW RD. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

■ Burial 2

□ Cremation 3

□ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) RESTHAVEN MEMORIAL 3/31/2004 FREDERICK, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SKILES FUNERAL HOME EMMITSBURG, 210 W. MAIN ST. POB 427, MD. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician MOUNS /Medical Due to (or as a consequence of) Examiner sta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Attanding Physician: The taw requires that the death certificate be executed burial-tran Due to (or as a consequence of): the attending physicien Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ eq 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy rmed? 2⊠ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide ō Hospitel 29a. Certifier 🖄 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier HEGAZIMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), A- 2. HEGHZI MD21702 + rederick Thomas Johnson Drue 46 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2004 Registrar

			1 - For State Registrar	State of Marylar	nd / Depa		Health and	Mental Hyg		200	
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Las EDWIN JOSEPH A. Facility Name (If not institution, give	HORNEY street and number)			or Location of Deat	2. Date of Dea Month MARCH	27 4c. (2004 County of D	1 5:25a M
	Funeral Director		210-30-0902			Risir If Under 1 Year Months Days		8. Dale of Birth (Month, Dey June	1	9.1 1926	Birthplece (Stete or Foreign Country) Maryland
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	be filed within 72 hours after death with the Marylen tal Hygiene. de they than "natural", or itema 23a or 28a-f show other than "natural", or itema 23a or 28a-f show event, the Medical Examinar most be untified at	by Funeral Director	5 Hedgerow Hol	12. Was Decedent Ever in U Armed Forces? 1 \(\text{Yes} \) 2 \(\text{X} \) No	l.S. 13.	1997 Was Decedent of H		Specify Yes or No- to Rican, etc.)		J.S.A 4. Race - A Black, W	merican Indian,
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Maryland 21215-0036	filed within Hygiene. other then ent, I've Me	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5 +		nister	,	me (First, Middle,	Adv	renti	n Day st Church
Marylar	should and Mer le marke sumatic	ToE	Aldridge Horne 19a. Informant's Name/Relationship (7 Miriam H. Horne	ype, Print)	1	ng Address (Street	and Number or R		r, City or		
Baltimore, I	8°2 = 5		20a. Method of Disposition 12 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	20b. I	Disponentery, creations	osition (Name of matory or other pla	сө)	Date	20c. Loc		or Town, State
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68760,	icate be executed physicien and s the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Evid theory is Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect c. Due to (or as a consect d.		Fuilone					e1.3 years
.O. Box	death certif e attending d for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3	□Ectopic pregnanc □ Other (specify) _	у		2:	3d. Date of Month	deliv ery Day Year
ords, P.	w requires that the been signed by the should be detache	ρ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	inderlying cause gr	ven in Part I.		es 2 L	_	e to the cause of death? Probably 4 □Unknown
of Vital Record	The law ate has b page 2 sl	Completed						24a. Was a autop: perfor 1 Yes	sy med? 2 No	death	autopsy findings available to completion of cause of ? es 2 No
₹	Physician: This certifical aldirector, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	EB/Outpatier	2 3 DOA Ott		ath <i>(Check only or</i> Home 5□Resid		□Other (S	nacitu)
	ding h. After fune	ertification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time o Injury	f 28c. Inju Wo	and the same of th	28d. Describe h			роспу
Division	E 15 6	O	3 Suicide 6 Could not be determined	building, etc. (Speci	(y)			City or Tow	m, State)		Rural Route Number,
	Hospital 24 hours a Funeral letely filled	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medicel Examone)	ysician: To the best of my knowing hiner: On the basis of examination and manner stated.	owledge, deat ation and/or in	n occurred at the ti vestigation, in my (me, date and place opinion, death occi	e, and due to the durred at the time, d	ause(s) a date and	ind manner place, and c	as stated. due to the cause(s)
9:	To the within 2 To the camplet	Me	29b. Signature and title of certifier	ulas f		29c. Licens		2	29d. Date	signed (Mo	onth, Dey, Year)
			Juseph K.	weidner fr	M)		44373		3	29/2	004
			30. Name and address of person who do Joseph K. We:	idner. Tr.			lonial	May Die	1 m	C	MD. 21911
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	Anniel 3		nay KIS	1110	Sun	MD - 21911

Physicia		1- For Amend Item #5 Registrar		Cer	uncate of	Deam		Reg. No.	004	099
	an	Decedent's Name (First, Middle, Last	t)				2. Date of Do Month	Day	Year	3. Time of Dea
/Medic	al	MARGARET		HARR			MARCH 1			10:00
Examin	er	4a. Facility Name (If not institution, give	•		4b. City, Town, o		eath		nty of Death	
uneral		5.f10 Segity Names 6. Segity N		ast birthday)	ROCKVIL If Under 1 Year	If Under 24 h	Irs. 8. Date of Bi	rth	GOMERY 9. Birth	place (State or Fo
irector		110-09-1208 110-19-1268	□M 2\\ F 86	Yrs.	Months Days	Hours M	in. (Month, D. 02/12/1	ay, Year) 1918	HUNG	ntry)
2		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	nation.					
show adul	ō				Jation					10d. Inside City L 1 X Yes 2
28a-	Director	MARYLAND MONTGOMER 10e. Street and Number	RY ROCKV	TILLE	10f. Zip Code			10g. Citizen	of What Cou	
3a or		5901 MONTROSE ROAD	N1209		2085	2		U.S.A		ntry
E LUIT	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13. V			(Specify Yes or No erto Rican, etc.)	o- 14. F	Race - Ameri	
an "natural", or items 23a or 28a-1 shov Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2∑ No		епо нісап, etc.)		Black, White, c <i>ify:</i> WHI	
natur lical l	Completed	15. Decedent's Edu (Specify only highest grad	ucation		ent's Usual Occup		vertica	16b. Kind of	f Business/In	dustry
than "i	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	lite. D	kind of work done OO NOT use retire	duning most of v d)	vorking			
		12		HOMEMA	AKER			OWN H		
2 0	Be	17. Father's Name (First, Middle, Last)					lame (First, Middle	, Maiden Sum	name)	
marked o	7	EUGENE 19a. Informant's Name/Relationship (7)	GRA		- 4 11 (01	BERTHA	0/0		FRIEDM	
7 is m traum		ROBERTA HARRIS/DAU					Rural Route Numb			
item 27 is marke	Ĭ.	20a. Method of Disposition	20b. Pla	ace of Dispos	sition (Name of		209, ROC	20c. Locatio		
10 = 5		1 X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	nemoval from State	-	atory`or other pla 1. GARDEI	· 1	16/2004			
Important: If ite any injury or of	Ī	21. Signature of Funeral Service Licens								AND
E E S		Manda X	adolika	109	VARD SAGI 91 ROCKV	EL FUNER LLLE PIK	RAL DIREC	TION, I ILLE, N	INC. MD 208	52
		23a. Part1. Enter the disease, or complishock, or heart failure. List only o	lications that caused the death.							Approximate Interval Between
/sician		Immediate Cause (Final	a LUNG CANCER							Onset and Dea
ledical		resulting in death)	Due to (or as a conseque	ence of):					I	TONTHS
aminer			b							
sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ence of):						
and al-trar	Examine		c. Due to (or as a conseque	ence of):						
	dical E									
g phy as the	edic		0.							
attending f	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnand					23d. [Date of delive	ery
the atte	icla	in the past 12 months? 1 □ Yes 2 🛣 No	1 Live birth 2 Fetal of 4 Pregnant at time of dea		Ectopic pregnancy Other (specify)	·		٨	Vionth	Day Yea
	Physic	9 🗍 Unknown	9□ Unknown							
by t	by	Part II. Other significant conditions con	ntributing to death but not result	ting in the un	derlying cause giv	en in Part I.				ne cause of dear
engi pe q		HYPOTHYROIDISM					1 X)	Yes 2 □ No	3 🗆 Prob	ably 4 Unk
engi pe q	eted						24a. Was	osv	prior to cor	psy findings ava npletion of caus
igne be d	npleted									
ate has been signe page 2 should be o	Completed						perfo 1 ☐ Yes	2 X No	death? 1 ☐ Yes	2□ No
ate has been signe page 2 should be o	Be	25. Was case referred to medical examiner?	dospital:xx		Oth	or	perfo 1 ☐ Yes eath (Check only o	2 🖾 No	1 🗆 Yes	
his certificate has been signe at director, page 2 should be o	To Be	examiner?	28a. Date of Injury 2	R/Outpatient		er: 4 🗆 Nursing	perfo 1 □ Yes eath (Check only of Home 5 □ Resid	2⊠ No nne) dence 6 □C	1 ☐ Yes	
his certificate has been signe al director, page 2 should be o	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	1 □ Inpatient 2 🖸 E		28c. Injun	er: 4 🗆 Nursing	perfo 1 ☐ Yes eath (Check only o	2⊠ No nne) dence 6 □C	1 ☐ Yes	
his certificate has been signe at director, page 2 should be o	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hom	28b. Time of Injury	28c. Injun Work	er: 4 □ Nursing y at k?	eath (Check only of Home 5 Residue) 28d. Describe 1	2 No one) dence 6 Conow injury occurrent and Nur.	1 ☐ Yes	
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Director: After this certificate has been signe in by the funeral director, page 2 should be o	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only 2 Medical Examine)	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify) sicien: To the best of my knowliner: On the basis of examination	28b. Time of Injury	28c. Injur Wor M 1 □	er: 4 Nursing y at k? Yes 2 No ne, date and pla pinion, death oc	eath (Check only of Personal P	2 No dence 6 Conow injury occions injury occion injury occion injury occion injur	1 ☐ Yes Other (Specify urred mber or Rura manner as st a, and due to	/ Route Number, ated. the cause(s)
To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be or	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Continuestigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify) sicien: To the best of my knowliner: On the basis of examination	28b. Time of Injury	28c. Injum 28c. Injum Wor M 1 et, factory, office occurred at the tim estigation, in my o	er: 4 Nursing y at k? Yes 2 No ne, date and pla pinion, death oc	eath (Check only of the coursed at the time,	2 No ldence 6 Co now injury occ Street and Num n, State) cause(s) and r date and place	1 Yes Other (Specify urred manner as st e, and due to	I Route Number, ated. the cause(s) Day, Year)
Director: After this certificate has been signe in by the funeral director, page 2 should be o	edical Certification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Continuestigation 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hombuilding, etc. (Specify) sicien: To the best of my knowliner: On the basis of examination and manner stated.	Reb. Time of Injury	28c. Injur Wor M 1 = 28c. Injur Bot, factory, office occurred at the time astigation, in my or 29c. License D0059	er: 4 Nursing y at k? Yes 2 No ne, date and pla pinion, death oc	eath (Check only of the coursed at the time,	2 No dence 6 Conow injury occurs, State)	1 Yes Other (Specify urred manner as st e, and due to	I Route Number ated. the cause(s) Day, Year)

			_	State of Man						Mental Hy	giene	
		•	1 - Stete Registrar		-		tificate				Reg. No. ZUU	
	Physicia	an	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	ath Day Yea	1 0 14
	/Medic	al .	Ruth Howell H				4h Ciby I	Four or	Location of Deat	March .	15, 2004 4c. County of Do	9:50 a M
	Examin	er	Holy Cross Ho						Spring	"	Montgo	
ĕ.	Funeral	100	5. Social Security Number 6. Se		In yrs. las	t birthday)	If Under		If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da		Birthplace (State or Foreign Country)
0. +	Director		263-22-8318 Usual Residence of Decedent	JM ZEJF	83	Yrs.						lorida
	/land	}	10a. State 10b. County	1	0c. City, 1	Town or Lo	cation					10d. Inside City Limits
	a-fsh	ctor	Maryland Montgom	nery	S	ilver	Spri	ng				1 ☐ Yes 2 ☑ No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number				10f. Zip				10g. Citizen of What	Country?
	eath v	Funeral	3330 North Leisur	e World Bl				0906 ent of Hi		pecify Yes or No	USA - 14. Race - A	merican Indian,
0	of the d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No						pecify Yes or No to Rican, etc.)		
2	hours after turs!', or Ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			I□Yes 2				Specify: W]	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Hygiene. de Hygiene. de other than "naturst", or Items 23a or 28a-f show svent, the Madical Examiner cust be notified at	Completed	15. Decedent's Edi (Specify only highest grad	de completed)		16a. Deced (Give : life. L	lent's Usua kind of wor OO NOT us	k done d	uring most of wo	rking	16b. Kind of Busine	ss/Industry
212	filed within 72 Hygiene. Ither then "nater, the Madic	ошо	Elementary/Secondary (0-12) 12	College (1-4or 5+)		P1	ant A	ssig	gner		Telephone	Company
פ	be filed ital Hygi d other svent, I	Be C	17. Father's Name (First, Middle, Last)						18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
<u> </u>	Ment Ment Marke Marke Ment Ment Ment Ment Ment Ment Ment Men	٩	Joe Mason Howell	Octob		10h Mailin	- Address	(Stroot o		ble Coun	tryman er, City or Town, State	a Zin Codo)
<u>a</u>	d 2 st th and 27 is n traun		James R. Henkel J	_		3330	North	Lei	Lsure Wo	rld Blvd		s, 21p Cooe)
ē,	S 1 ac itsm itsm		20a. Method of Disposition		20b. Plac	natary, cran	natory or of	ther place	Marc	Date h 18,	20c. Location - City	or Town, State
Ē	Page nent c		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify)	Removal from State)	Park	klawn	Mémo: ark	rial	Hare	04	Rockville	, Maryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked sny injury or other traumatic so one.		21. Signature of Funeral Service Licens	iee. At 1/2		Fı	canci	s J.	s of Facility Collins	Funeral	Home Inc	•
8	10200		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused th	e death.	Do not ente	00 Un	iver	sity Blv g, such as cardia	d W	Silver Spr	ing MD 20901
	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	one cause on each line. Carcimo:								Interval Between Onset and Death
4	/Medical		resulting in death)	Due to (or as a c			У					
	Examiner	<u>.</u>	Sequentially list conditions,	b. Chronic Due to (or as a c			ive L	ung]	Disease			
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Atheros			art I)ice:	256			
ó	le be executed ysician and le burial-transit		resulting in death) Last	Due to (or as a c								
8760,		dical	•	d								
x 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	pregnanc						23d. Date of	delivery
. Box	death e atter	iclar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at tin			Ectopic pri Other <i>(sp</i>				Month	Day Year
о. О	res that the de signed by the a be detached t	Phys	9 Unknown	9□ Unknown		11000			-07/17/27/2	22a Did t	shassa usa santribut	to the cause of death?
ds,	signed	i by	Part II. Dther significant conditions of Atrial Fibrillat					ause give	en in Part I.			Probably 4 Unknown
202	w require been sig should b	letec	1101 1101 1101	zon, zarge						24a. Was	an 24b. Were	autopsy findings available
Re	Physician: The lav this certificate has al director, page 2	Completed by								autor	osy prior death	to completion of cause of
a	ian: artifica ctor, p	Be C	25. Was case referred to medical examiner?							ath (Check only o		
5	Physic this ce al dire	은	1 ☐ Yes 2 🛣 No	Hospital: 1 図 Inpatient		R/Outpatien			4 Nursing r		dence 6 Other (S	pecify)
ono	Ilng After funer	tlon	27. Manner of Death 1 (∑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	rear)	Injury	M	8c. Injury Work	(? Yes 2 □ No	Zod. Describe	now injury occurred	
Division of Vital Records,	Attendi	Certification:	3 Suicide 6 Could not be determined	l l	y - At hom (Specify)	e, farm, str	eet, factory	, office		28f. Location (. City or To		Rural Route Number,
Ō	ital or A		7	Danding, oto.	(0,000,1,7)					,		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical		ysicien: To the best of a siner: On the basis of ea and manner state	xaminatio							
	fo the vithin to the comple	Me	29b. Signature and title of certifier	1/	=-		290	. License	number		29d. Date signed (Me	onth, Day, Year)
•	-1/2		· Mark	R M				D2	7865		March 16	, 2004
	2		30. Name and address of person who d									
	Sta	to	Mark Li M.D. 1 31. Date filed (Month, Day, Year)	721 Univers	s Signatui	re /	-			MD 2090	12	
	Registi		MAR 18 20		par	19	Spo	uks				

		1	For Stete Registrar	Jiaie U	Marylan	•	rtificate					Reg. No	- 211111		} 7
			1. Decedent's Name (First, Middle, Las	t)							2. Date of De Month	ath Da	ıy Year	3. Time of Death	
	Physicia /Medic	al	Frank W. Holt, S								March	11,	2004	6:20 P	u
	Examin		4a. Facility Name (If not institution, give				4b. City, To		Location of	of Death			. County of Death		
			Atlantic General			land hinth days	Berl:		If Under:	24 Hrs	9 Date of Ris		Worceste		
	Funeral Director		218-34-/1/2	x ⊠M 2□F	7. Age (In yrs. 66	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Dec. 3	1, Year)	937 Wash	pplace (State or Foreignity) intry) ington, De	<u></u>
	and **	1	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limit	S
	Many -f sh	to	Maryland Worcest	er		Berlin								1 ☐ Yes 2 ☒ N	0
	death with the Maryland ims 23a or 28e-f show r roust be notified at	Director	10e. Street and Number				10f. Zip Co	ode				10g. Ci	itizen of What Cou	intry?	
	23a	la l	22 Windward Cour				218				4 11 11		USA	to a to all a	
	ar dea	Funeral	11. Marital Status	Armed For		l.S. 13.	Was Deceden If Yes, specify	Cubar	n, Mexican	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	o-	14. Race - Amer Black, White		
36	ours after death wit irel', or Items 23a c	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes If Yes, Giv Year or Da	ates: VIE	<u>t</u> nam	1 ☐ Yes 2 ☐						Specity: Whi	.te	
Baltimore, Maryland 21215-0036	be filed within 72 hours after ital Hygiene. Id other than "neturel", or Ite event, I'e Medical Exertica	ted	15. Decedent's Ec	lucation		16a. Dece	dent's Usual C	Occupa	tion	t of workii	na	16b. K	Kind of Business/l	ndustry	
215	be filed within 72 ho tal Hygiene. d other then "netui event, tre Medical	Completed	Elementary/Secondary (0-12)	College (1		life.	DO NOT use	retired)			,9	_			
21	ed wi	ပ္ပ		4	·	Pro	gram Ma	ana		or's Name	(First, Middle			overnment	_
ם	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)												
<u> </u>	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, I's M	2	Kenneth J. Holt			19b. Mail	ng Address (5	Street a			V. Pars		or Town, State, Z	ip Code)	
Ma	d 2 sl th an th an treur		Ann K. Holt/ Wif								rlin, N				
ම	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any njury or other treumatic es		20a. Method of Disposition		20b. I		osition (Name matory or othe		.	D	ate		ocation - City or 1	Town, State	T
ē	ages ent of ry or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 3 ☐ Other (Specific		State		tan Cre		! *	March 200		Ale	exandria	, Virginia	
릁	in in in in in in in in in in in in in i		21. Signature of Funeral Service Lice	1 /	, ince	ropoli F	2. Name and	Addres	s of Facilit				me Inc.		
ä			X West W	Ma		5	00 Univ	ver	sitv	Blvd.	. W.,	Sil	ver Spri	ng, MD 209	01
			23a Part. Enter the disease, or com shock, or heart failure. List only	plications that cone cause on e	aused the dea	th. Do not en	ter the mode	of dying	g, such as	cardiac o	r respiratory a	arrest,	-	Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	M	alian	nant	me	la	nor	na				Onset and Death	
	/Medical		resulting in death)	Due to (or as a conte	quence of):	0		,						
11	Examiner		Sequentially list conditions,	h	ereb	ial	Mu hen Emk	$n_{\mathcal{U}}$	VYE	iay	-				
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Pi	ma	querice oi).	Sml	1	1	~					
0 -	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quenc - of):	Crit	-	70				-		
760,	sician ar burial-t	calE		4											
687	ificate g phy as the			- 0.					-						
t ŏ	itending Physicien : The law requires that the death certificate be executed isath. tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		□Ectopic preg	nancy				1	23d. Date of deli		
B.	deatl	sicia	in the past 12 months? 1 \(\subseteq \text{Yes} 2 \subseteq \text{No} \)		ant at time of		Other (spec						Month	Day Year	
€.0 .0	at the by the	Phys	9 Unknown						un in David		230 Did	tobacco	use contribute to	the cause of death?	
A 's	igned be de		Part II. Other significant conditions	contributing to de	eath but not re	sulting in the	underlying cau	ise give	an in Pairti	ı.				bably 4 Unknow	VΠ
cord	The law requires that ste has been signed b page 2 should be deta	Completed									10)				
, a	alaw hasb e 2 sh	nple									24a. Was		prior to death?	topsy findings availab completion of cause of	f
193 B B	: The cate l										1 ☐ Yes	2 🔯 N		2 🗆 No	
3/// Vital	icien certifi ector	Be	25. Was case referred to medical examiner?	Hospital:		7-2:0		Othe			(Check only		a Cloth /0	***	-
70	Physicien: r this certific ral director,	1.	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	-	ER/Outpatie		c. Injury Work	4 🔲 N		me 5 ⊔ Hes 28d. Describe		6 ☐ Other (Specury occurred	ary)	
· •	ding h. After fune	tion	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mon	th, Day Year)	Injury	М		<br Yes 2 □	No					
Division	or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not b	e 28e. Place	of Injury - At I	nome, farm, s	treet, factory,	office						ral Route Number,	
Si	in Dir	Certification;	4 - Homicide determined	buildi	ing, etc. (Spec	iry)					City or To	iwii, Siai	10)		
	Hospite 24 hours Funerel itely fille	Medical C	29a. Certifier 1 Certifying Pl (Check only one)	miner: On the b	e best of my kn easis of examin	owledge, dea	th occurred at nvestigation, in	t the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time	cause(s	s) and manner as nd place, and due	stated. to the cause(s)	
4.0	To the within 2 To the comple	Mec	29b. Signature and the of certifier						e number				ate signed (Month		
	. 1		> 11 Vlm	AN			D	00	060)53	55	Mar	nch 11,	2004	
,	D_{A} ,		30. Name and address of person with	completed caus	se of death (Ite	m 23a) (Type								<u> </u>	
			Nadia Angov M.D		Health			er1	in, M	1D					
		ate	31. Date filed (Month, Day, Year) MAR 15 2	004 32. F	Rogistrar's Sign	nature 4	Spo	not.	2						
	Regist		INITED TO A TO A TO A TO A TO A TO A TO A TO	11117 [- · ·	//	/ //	,							

			1 - For State Registrar	State of Ma	ryland		artmen rtificat			and M		Reg. No.	211	04	45 65	938
¥ -	Physici /Medic		 Decedent's Name (First, Middle, Las Gordon Edward Hul 								2. Date of De Month March	16, Day		Year	3. Time o	
	Examir	-	4a. Fecility Name (If not institution, give Carriage Hill-Bet)					Town, or hesc	Location o	of Death			County of		ry	
	Funeral Director		5. Social Security Number 137–20–9937 6. Security Number 12	7. Age	(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min	8. Date of Bir (Month, Da May 5,	iv. Year)		Coun	Jerse Jerse	
	show ed et	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome:	1		Town or Lo				-				1	0d. Inside C	City Limits
	or 28a-f	Direct	10e. Street and Number				10f. Zip		\			•	zen of Wh		•	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show important: If item 27 is marked other than "natural", or items 23e or 28e-f show any joury or other traumatic event, ite Madical Examiner mast be notified at 2006.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E- Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: W	·Worl	.d	Was Decedif Yes, spe			gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)			- Americ White,	an Indian,	
Maryland 21215-0036	within 72 hounders. The mature is Medical E	Completed	15. Decedent's Ed (Specify only highest gra	ucation	-)	16a Dece	kind of wo DO NOT u	rk done d se retired	during most f)	t of worki	ng		nd of Busi		dustry	
land 2	should be filed vond Mental Hygie marked other tumatic event, III	To Be Co	17. Father's Name (First, Middle, Last) Edward Hubel	3,		Luico	, 1 / 1 d.	7.1.31	18. Mothe	rs Name	(First, Middle)len	1				
, Mary	and 2 shows ealth and N m 27 is manar trauma		19a. Informant's Name/Relationship (1) Judy H. Lukacs/ Da			11009	Harı	iet	Lane,	, Ker	A Route Numb	n, M	D 208	395		
Baltimore,	it. Pages 1 ritment of H ritant: If ite njury or ott		20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune a Service Sicen)	Memo	ce of Disponetery, creater	Park		1	larch 200	n 18, 04 ert A.	Roc	kvill	Le, I	own, State Maryla eral l	
Ba	Dermi Depa Impo any ir	8 9	23a Part . Firef the disease, or companion, broken failure. List only	MO	00689	Ве	theso	la-Ch Beth	nevy (nesda,	Chase Mai	Inc.	755 2081	7 Wis 4-350	con	Sin A	venue,
9760,	Physician /Medical Examiner the pnrial-fransit in purial-fransit	licai Examiner	Immediate 'Cadsa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	a. Chronic (Due to (or as a b. Coronary Due to (or as a c. Due to (or as a d.	Arte	nce of): ry Di			ary Di	iseas	se				Onset and	
.O. Box 6	death certifi e attending ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1∐Live birth 2 4∐Pregnant at t 9∭Unknown	2 Fetal d	leath 3	⊒Ectopic p ⊒ Other (s)		,				23d. Date Mont		-	Year
s, P	Se 75 6	by	Part II. Other significant conditions o	ontributing to death but	t not result	ing in the u	inderlying (ause giv	en in Part I.			obacco u Yes 2			he cause of bably 4	
Record	The law ate has b page 2 s	Completed							 		24a. Was auto perfo 1 \(\text{Yes}	psy ormed?	pri	or to cor ath?	psy findings mpletion of a 2 No	available cause of
Vital	sician: certific rector,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatien	• 2□E	R/Outpatier	nt 3 D	Oth	ac		me 5 Resi		6 Other	(Specif	(v)	-
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Divi	e Hospital or Atten 124 hours after deat Funeral Director: letely filled in by the		4 Homicide determined	building, etc.	. (Specify)						City or To	w⊓, State)		Al Route Nur	nber,
	Hoy Hos	edical		ysician: To the best of niner: On the basis of and manner stat	examinatio											s)
	To the within 2 To the complet	W	29b. Signature and title of certifier	b		- 10			e number	-					Day, Year)	
,	2011		30. Name and address of person who				Print)				-4			10	4	
	Sta		Truong Bao, M.D. 31. Date filed (Month, Day, Year)	32. Registra				race		Lners	sourg,	מוא בי	00/4			

HUBEL, GORDON

		1 - For State Registrar	State of Maryland	l / Depa <i>Cer</i>	rtment of H	ealth and M Death		iene 2 ()	04	09939
	ician	Decedent's Name (First, Middle, Last) Susan Mary Hunter	•				2. Date of Death Month March 14	Day	Yeer	3. Time of Death 7:30 PM
	dical niner	4a. Fecility Name (If not institution, give si				Location of Death	1102 011 1	4c. County of		
Funer		4505 Saul Road 5. Social Security Number 184-42-9917 6. Sex	7. Age (In yrs. last	st birthday) Yrs.	Kensing If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 13,	Year)	gomer 9. Birthple Country Penns	ce (Stete or Foreign y) sylvania
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If term 27 is marked other than 'natural', or items 23a or 28a-1 show any fujury or other traumatte event, the Medical Evans withing the calified at		Usual Residence of Decedent 10a. State 10b. County Maryland 10b. County Maryland Montgor 10e. Street and Number 4505 Saul Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) James F. Hun 19a. Informant's Name/Relationship (Typ)	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: action completed) College (1-4or 5+) 5+	. 13. V II 16a. Deced (Give I life. L	nsington 10f. Zip Code 2089 Vas Decedent of Hi Yes, specify Cubai Yes 2 No ent's Usual Occupe and of work done a O NOT use retired, ections	spanic Origin? (Spen, Mexican, Puerto Specity: atton turing most of works) Manager 18. Mother's Name	ng 10 (First, Middle, Mu McEvo	Dg. Citizen of W US. 14. Race Black Specify: 16b. Kind of Bus Federa1 faiden Sumame	hat Countr A - Americar, White, et Whit	d. Inside City Limits 1 Yes 2 XNo y? In Indian, Ic. te istry
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is	Duce. Of	Gary L. Garrison/ 20a. Method of Disposition 1 □ Burial 2 ☆Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or combilion shock, or heart failure. List only one	amoval from State 20b. Pla cen Meti	ropoli ropoli Fr	ition (Name of atory or other place tan Crema Name and Addres ancis J. O Univers	9) March story 2(s of Facility Collins 3	n 15, 004 Funeral	Alexand Home I ilver S	ria, nc. pring	m, State Virginia , MD 20901 Approximate nterval Between
The law requires that the death certificate be executed are been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, learning to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE:	Metastatic B: Due to (or as a conseque Due to (or as a conseque	ence of):	Cancer					Onset and Death 6 years
w requires that the death certific been signed by the attending I should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery h D	ay Year
requires that een signed	ted by F	Part II. Other significant conditions cont	nbuting to death but not result.	ling in the un	derlying cause give	n in Part I.				cause of death?
vician: The law certificate has b	Comp							ed? de	ere autops for to comp ath? Yes 2	sy findings available bletion of cause of
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the tuneral director, page	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	R/Outpatient 8b. Time of Injury	28c. Injury Work M 1 \(\text{Y}	at // res 2 No	ne 5 ∰Resider 28d. Describe hov	nce 6 Other	d	
pital or Al		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)			- A	28f. Location (Stre City or Town,	State)	- 4	
the Hos thin 24 hos the Fund ompletely f	Medical		ician: To the best of my knowler: On the basis of examinatio and manner stated.	on and/or inv	estigation, in my op	inion, death occurre	ed at the time, da	te and place, and de and place, and place, and place, and de and place and de a	d due to th	he cause(s)
D		1 ly	Stoul	W	D182			March 1		
r		30. Name and address & person who cor Stephen Staal M.D.	1221 Mercan	tile I		go, MD 20	774			
	State istrar	31. Date filed (Month, Day, Year) MAR 1 6 200	32. Registrar's Signatur	4	Sparks	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09940 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MAE JACKSON 6:05 AM ELSIE 11, 2004 MARCH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY Rockville Collingswood Nursing Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 11 6. Sex 9. Birthplece (State or Foreign 5. Social Security Number **Funeral** Hours Days Min. Maryland 1 M 2 F 93 Director 216-44-9410 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent, the Medical Exartament or notified at Rockville 1⊠ Yes 2 No Montgomery Completed by Funeral Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 315 Lincoln Avenue 20850 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. and I tem 27 is marked other than "natural", or ite 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Nat'l Naval Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Medical Center 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Henry Prather Evelyn Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 MD 20637 Beaver Ridge Rd., Karlton K. Jackson (Son) Gaithersburg, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of the Importent: If Ite any injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Mem. Park 3/19/04 Rockville, MD injury o 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 246 N. Wash. St., Rockville, MD 20850 un 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it ary, to using to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Que to (or as a consequence of) Completed by Physician/Medical Examiner The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ned by the atter in the past 12 months? Month Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No O 9 Unknown 9 Unknown ۵. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Physician: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 42 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2√2 No this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? To the Hospitel or Attending 5 Pending investigation 1 XX Katural ours after death. neral Director: Af filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funeral I 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies 29c. License number 4005,200 -11-04 20874 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 13219 Executive Park Ter, Germantown, M.D. Anushiravan Dadgar, 31. Date filed (Month, Day, Year) MAR 18 32. Régistrar's Signature

Registrar

Locales

antal

			Tor State Registrar	State of N	Maryland		artment o				Reg. No.	200	. 9 2 2	3
	Physici /Medic		Decedent's Name (First, Middle, Last UPTC		JACKS	SON				2. Date of De Month Mar		, 200	3. Time of Dea 4 4:45P	th M
	Examir		4a. Facility Name (If not institution, give				Germa	n, or Location Intown	l .		M	ounty of Dea	mery	
	Funeral Director		5/9-09-0996	ex 7.7 □ M 2□ F	Age (In yrs. la 88	ast birthday) Yrs.	If Under 1 Ye Months Da		Min.	8. Date of Bir (Month, Da Jan . 1	by Year)	16 9. Bir	thplace (State or For puntry) aryland	reign
	Maryland f show	or	Usual Residence of Decedent	omery	10c. City	, Town or Lo	ocation nantown	1					10d. Inside City Li	
	n with the I	al Director	10e. Street and Number 14010 Berryv		ad		10f. Zip Coo	0874			-	en of What C	ountry?	
980	d within 72 hours after death with the Maryland jene. I than "natural", or items 23a or 28a-f show I're Medical Examinat must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Whidowed 4 Divorced	12. Was Deceder Armed Force 1 XYes 2 [If Yes, Give Year or Dates	s?]No 		Was Decedent If Yes, specify 0			ecify Yes or No Rican, etc.)		4. Race - Am Black, Whi Specify:		
Maryland 21215-0036	within ene. than	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 6 th		or 5+)	(Give	dent's Usual Ockind of work do DO NOT use re ISTOdia	ne during mos tired)		-	Na	of Business it'l N edical	,	
yland 2	ould be filed Mental Hyg arked other	To Be C	17. Father's Name (First, Middle, Last) Ollie Jackso					S	aral	(First, Middle	on			
	s 1 and 2 sho if Health and Item 27 is m other traum		19a. Informant's Name/Relationship (19a Benjamin Jacks		ohew)	860	ng Address <i>(Str</i> 1 Ward esition <i>(Name o</i>	ield	Road		ther		, MB088	2
Baltimore,	permit. Pages 1 Department of H Important: If Ite sny injury or otl		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature Funeral Service Cen	0 0	CE	eca C	natory or other Church 2. Name and Ac	Cem 3	3/20/ ity SNC	04 OWDEN	Germ FUNE	antow	n, MD OME, P.2 MD 2085	
Si q	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or composition of the control of th	a. Con	i line.	.Ve He	er the mode of			or respiratory a	rrest,		Approximate Interval Betweer Onset and Deatt 1 year	
. Box 68760,	death certificate be executed the attending physician and ad for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	d	2 Fetal at time of de	ncy death 3[Ectopic pregna				23	3d. Date of de Month	livery Day Year	
rds, P.O.	law requires that the de as been signed by the a 2 should be detached f	by	9 Unknown Part II. Other significant conditions of	ontributing to death	but not resu		nderlying cause	given in Part	1.				the cause of death	
al Records,	The ate h page	Completed								1 Yes	psy ormed? 2 No	24b. Were a prior to death?	utopsy findings avail completion of cause 2 No	able of
Vital	ysici s ca dirac	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 🍇 No	Hospital:	atient 2 🗆 8	ER/Outpatier	nt 3 DOA	Other		n <i>(Check only c</i> ne 5. X Resi		Other (Spe	cify)	
ion of	nding Phi ath. r: After thi	atlon; T	27. Manner of Death CNsatural 5 Pending 2 Accident investigation		njury Da <i>y Year)</i>	28b. Time o Injury		Nork?	i	28d. Describe l	how injury	occurred		
Division	To the Hospital or Attending Physitin 24 hours after death. To the Funeral Director: Attenty completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	ZOC. FIALE UI	Injury · At ho etc. (Specify	me, farm, str	eet, factory, off	СӨ		28f. Location (3 City or Tou		Number or R	ural Route Number,	
	Hospl 24 hou Funer etely fill	edical	29a. Certifier (Check only one) Check only one)		of examinat									
	To the within To the compl	Me	29b. Signature and title of certifier	^ ^			29c. Lic	ense number			29d. Date	signed (Mont	h, Day, Year)	
,	6		P U - MIL		of classic /learn	2321/7	Print)	4312	U		MAR	CA712	0,2001	
20			30. Name and address of person who Dennis M. H	annon,	M.D.	290	l Olne	y-Sand	dy S	pring	Rd.,	, Olne	20832 2y, MD	
-2	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 8 20		strar's Signat	ture A	Some	61						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 09942 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yeer **Physician** Harriet Savige Johnson 16, 2004 March 5:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Wilson Health Center Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 25, 1920 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2₩F 83 191-16-2881 Director Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow any injury or other treametic event, the Medical Examiner must be natified a once. 1 TYes 2 □ No Director Md. Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 401 Russe11 Ave. 20877 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Savige Laurence Duane Ethel Mae Holderhaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lyall E. Johnson (Husband) Russell Ave. Gaithersburg, Md. 20877 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

1 ☐ Donation 5 ☐ Other (Specify) Chambers Crematory March17,2004 Riverdale, Md. 22. Name and Address of Facility Chambers Funeral Home & Crematorium, P.A 21. Signature of Funeral Service Licensee, #670 Anmas 5.0 namber 5801 Cleveland Ave. Riverdale, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician A cute Tubular Necrosis 3months resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner the attending physician and hed for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 🗆 Unknown signed by 1 d be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Alzheimers Disease certificate has been signector, page 2 should t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hyper tension 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident within 24 hours after death to the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 10 29d. Date signed (Month, Day, Year) Phisciella Coelletur-ty on. 041794 march 16, 2004

Registrar

Box 68760.

P.O. I

Division of Vital Records,

Russell Ave

Gaithersburg, mp 20879

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Priscilla Callahan- Lyon, MP

31. Date filed (Month Day, Year)

			For State Registrar	State of Mary	/land / D)	epartme C <i>ertifica</i>	nt of He te of D	ealth and I Death		ene 200	4 09943
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	/Medic Examin		4a. Facility Name (If not institution, given Holy Cross Ho					Location of Death	n	4c. County of De MONT	eath GOMERY
	Funeral Director		215-20-3/3/	Fex 7. Age (li	n yrs. last birth 81 Y	day) If Und Month	er 1 Year s Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May	1922 M	Birthplace (State or Foreign Country ar (1 and
	death with the Maryland ms 23e or 28a-f ehow rmust be notified at	_	Usual Residence of Decedent 10a. State 10b. County		Dc. City, Town						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	3a or		709 Lenmore	Ave., #D2	:3	101.2	208	350		U.S.	
350	n 72 hours atter death with the Marylan "natural", or Items 23s or 28s-1 show edical Examiner must be malified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 【★Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	ir in U.S.		edent of His ecify Cubar		pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc. Black
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Baitimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 ie marked any injury or other traumatic exonce.		1X Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specif	memoval nom State	20b. Place of C cemetery			em 3/1		·	
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	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate the formation of the country that initiated events resulting in death) Last	c. Hypert Due to (or as a co	ensio	n					
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Vital Records	The lar ate has page 2	Completed							24a. Was an autopsy performe	prior t death	autopsy findings available o completion of cause of ? es 2 \sum No
\ <u>\</u>	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient	2 ○ ER/Outp	patient 3 🗆 0	Othe	r.	ith (Check only one)		
וס ר	On 0 0	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Tir		28c. Injury Work		28d. Describe how		овспу)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	6 39a Blace of lainer	- At home, farm	М	1 🗆 Y	es 2□No	28f. Location (Stre City or Town,		Rural Route Number,
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	١		30. Name and address of person who Ghousia Sult		h (Item 23a) (T 121	ype, Print) 07 He1	ritag	e Park	Cir., S	ilver S	Spring, MD
40	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6 26	32. Registrar's	Signature	9 St	outs	1			

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 09944 Certificate of Death

Physician	
/Medical	
Examiner	

Funeral

Director permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryland Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural; or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the mospital or Atlanding Physician: The lew requires that the death certificate be executed within 24 hours effect death. To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, pege 2 should be deteched for use as the buriel-trensit
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	1. Decedent's Name	e (First, Middle, Le	est)					2	. Dete of D				of Death
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Ę		ed 2 Married	1 Yes 2	No	1□ Yes				Jan, 5151)		177	HITE	
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9	17. Father's Name (First, Middle, Last)				18. Mother's	Name (F	First, Middle	e, Maiden S	Su <i>rname)</i>		
To B	FREDERICK	A. HADI	·ΕΥ				VERA	J.	BREWE	7 P			
-	19a. Informant's Na			19h	Mailing Addre	ss /Stree					Town State	Zin Codel	
,	PATRICIA				99 NORT								.710
	20a. Method of Disp		TOTEK		Disposition (N		гыр г		Date		·		+/10
			Removal from State	a a mata s	y, cremetory or	other pla	ce)		Date	200. Loc	cation - City or	rown, State	
	4 Donation	5 Other (Specif	(y)	MT. CO	MFORT C	REMA	TORY	3/1	7/04	ALEXA	ANDRIA,	VA.	
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	2	- F.	8									7130 W.	
	23a. Pert1. Enter th	ea or com	plications that cause	d the death. Do n			WASHIN				16	Approxim	ate
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	Immediate Cause (I	Final	MIT TEN	E DD TVA	DTY 364T T	C37.4.37			*****				
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٤	1 ☐ Yes 2 🛣 1		Hospital: 1 Inpati				4 U Nursir	ng Home	5 🗆 Resi	dence 6	Other (Spe	_{cify)} HOSE	PICE
ü	27. Manner of Death	5 Pending	28e. Date of Inju (Month, Da	ry Year) 28b. Ti	ime of jury	28c. Injur Wor	y at k?	28d	. Describe	how injury	occurred		
at	2 Accident	investigation			М		Yes 2□No						
Ĕ	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Piece of in	ury - At home, far c. (Specify)	m, street, facto	ry, office		28f.	Location (City or To		Number or Ru	iral Route Nu	ımber,
ē			building, co	o. (opcony)					Only or 10	viii, Siate)			
a	29a. Certifier	1E Certifying Ph	ysician: To the best	of my knowledge,	death occurred	at the tir	ne, date and pl	lece, and	due to the	cause(s) a	nd manner as	stated.	
Medical Certification: To	(Check only one)	2 Medical Exam	niner: On the basis of and manner st	f examination and	or investigation	n, in my o	pinion, death o	occurred a	at the time,	date and p	lace, and due	to the cause	P(S)
ž	29b. Signature and t	itle of certifier	10/		29	c. Licens	e number			29d. Date	signed (Monti	h, Day, Year)	
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Registrar

DHMH 17 Rev 1/2001

Registrar

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	For State Registrar	State of Maryla		ificate of			10g. No. 20	04 099
	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	ith Day	Year 5 3c
Physician /Medical	ESTHER	KAMINSKY				March		007
Examiner	4a. Facility Name (If not institution, give		1		or Location of Death		4c. County of	
	HEBREW HOME OF GR 5, Social Security Number 6. S		TON I	ROCKVILL If Under 1 Year	E If Under 24 Hrs.	8. Date of Birtl	MONTGO	MERY 9. Birthplace (State or
Funeral Director		□M 2\\ F	90 Yrs.	Months Days	Hours Min.	(Month, Da) 03/01/1	v. Year)	NEW YORK
	Usual Residence of Decedent	100.0	it. Town or Loo	ntine				10d. Inside City
ra nous and bean with the maryend insturel, or items 23s or 28s-1 show dical Evaniner must be notified at eted by Funeral Director	10a. State 10b. County		ity, Town or Loc	ation				1 ☑ Yes
be notified by notified Director	MARYLAND MONTGOME	RY ROC	KVILLE	101 70- 0-40			10g. Citizen of W	
Dir.	10e. Street and Number	_		10f. Zip Code				
or items 23a Tringr must b Funeral I	6121 MONTROSE ROA 11. Marital Status	12. Was Decedent Ever in I	J.S. 13. W	20852	Hispanic Origin? (Sp	ecify Yes or No-	U.S.A	- American Indian,
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b b	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2Ã No	Specify:		Specify:	WHITE
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Item 27 te marke other traumatic To	19a. Informant's Name/Relationship (and Number or Run			
Item 27	SUSAN PERSH/DAUGH 20a. Method of Disposition		1 / 28 G Place of Dispos			ROCKVII Date		YLAND 20854 City or Town, State
Important: If Ite eny injury at of ance.	1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cremi	atory or other plac	ce)			
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eny injury pt o	21. Signature of Funeral Service Licer	1500			ess of Facility EL FUNERA			
	23a. Part1. Enter the disease, or com	nlications that aused the dea			ILLE PIKE			Approximate Interval Between
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Director: After this certification by the funeral director.	examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 2 Accident 6 Could not b determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spec	28b. Time of Injury home, farm, streethy)	M 1 = et, factory, office	ry at rk? Yes 2 □ No	28d. Describe h 28f. Location (S City or Tow	ow injury occurre itreet and Numbe n, State)	or Or Rural Route Numbe
Nirector: After this certiful by the funeral director. rtffication: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Nettiral 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifier 1 Certifying Physical Exam	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specingsician: To the best of my kr	28b. Time of Injury home, farm, streetify)	M 1 = et, factory, office	ry at rk? Yes 2 No	28f. Location (S City or Tow	ow injury occurre itreet and Numbern, State)	or or Rural Route Number
in by the funeral director rtification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Nettral 5 Pending investigation 3 Suicide 6 Could not b determined 29a. Certifier (Check only one) 1 Certifying Phase Could not b determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specials: To the best of my kr	28b. Time of Injury home, farm, streetify)	M 1 = 28c. Injut Wor Not the time t, factory, office occurred at the time satigation, in my control occurred at the time satigation, in my control occurred at the time satigation.	ny at rk? IYes 2 No me, date and place, ppinion, death occur	28f. Location (S City or Tow and due to the cred at the time, c	ow injury occurre itreet and Numbern, State) cause(s) and mar date and place, a	or or Rural Route Number or or stated. and due to the cause(s)
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Jie Dourn. Jie to After this certiful by the funeral director. It if it at ion: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specinysician: To the best of my kriminer: On the basis of examinand manner stated.	28b. Time of Injury home, farm, streatify) nowledge, death lation and/or investigation	M 1 = 28c. Injut Wor Not the time t, factory, office occurred at the time satigation, in my control occurred at the time satigation, in my control occurred at the time satigation.	ny at rk? IYes 2 No me, date and place, ppinion, death occur	28f. Location (S City or Tow and due to the cred at the time, c	ow injury occurre itreet and Numbern, State) cause(s) and mar date and place, a	or or Rural Route Number or or stated. and due to the cause(s)
leath. To after this certification of the funeral director cation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not b determined 29a. Certifier (Check only one) 1 Certifying Prone) 29b. Signature and title of certifier	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Specinysician: To the best of my kriminer: On the basis of examinand manner stated.	28b. Time of Injury home, farm, streatify) nowledge, death lation and/or investigation	M 1 = 28c. Injut Wor Not the time t, factory, office occurred at the time satigation, in my control occurred at the time satigation, in my control occurred at the time satigation.	ny at rk? IYes 2 No me, date and place, ppinion, death occur	28f. Location (S City or Tow and due to the cred at the time, c	ow injury occurre itreet and Numbern, State) cause(s) and mar date and place, a	or or Rural Route Number or or Rural Route Number oner as stated. and due to the cause(s)

			For State Registrar	State of Marylan	d / Depa <i>Cer</i>	artment o	f Health and of Death	d Mental Hy	giene Reg. No.	2004	09947
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
.4	Physici /Medic		LaVerne L. L1	ewellyn_				March	06	2004	6:20 a M
	Examin	-3	4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Tow	m, or Location of De	eath	4c. (County of Death	
			Prince George H		laat hirthday)	Cheve If Under 1 Y		Hrs. 8. Date of Bir		ince G	eorge
	Funeral Director		1 🗆	7. Age (In yrs. 49	Yrs.			(Month, Da	y, Year)	1054 D	otace (State or Foreign otry)
			577-76-1843 Usuat Residence of Decedent					octobe.		1904 D	
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	Od. Inside City Limits
	e Ma	ctor	Md Prince G	eorge Cap	ital 1	Height					1∰Yes 2 No
	में 20 हैं 10 हैं	Director	10e. Street and Number			10f. Zip Cod	de		10g. Citiz	zen of What Cour	ntry?
	death with the Maryland me 23a or 28e-f show fritual for codified at	rai	4231 Rail Street	2. Was Decedent Ever in U.	C 12.1	207		(Specify Yes or No	USA	4. Race - Americ	en Indian
	Item Item	Funeral	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ☐ Yes ② No	.s. 13. t	f Yes, specify	Cuban, Mexican, Pu	uerto Rican, etc.)		Black, White,	etc.
336	urs af	by	3 ☐ Widowed 4 ☐ Pivorced	If Yes, Give Year or Dates:		1□Yes 2🔼	No Specify:			Specify: Blac	k
21215-0036	72 hours after natural', or ite dical Examen	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	dent's Usual O	ccupation one during most of	working	16b. Kir	nd of Business/In	dustry
21	within 7 ene. than r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use re	etired)				
2	e filed within al Hygiene. I other than vent, the Me		12th		Bus D	river	19 Mothors	Name (First, Middle,			rge Co.Sc
gue	be fill	Be	17. Father's Name (First, Middle, Last)							ourname)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 Is marked other than "natural", or Iteme 23a or 28e-f show other traumatic avent, the Modical Evariation ruth for invitile 1 at	2	Leo Harrington 19a. Informant's Name/Relationship (Typ.	oe. Print)	19b. Maitir	na Address (St.		ece Dews		Town, State, Zip	(Code)
Ma	id 2 sho lth and 27 is ma		Fariece Altice (11 CAN 1800 NO.			I.E. Was			
	Health Item 27 other tr		20a. Method of Disposition	20b. F	Place of Dispo	sition (Name of natory or other	of colace)	Date		cation - City or To	
30	Pages ent of ht: If i		YDBurial 2 ☐ Cremation 3 ☐ Re *4 ☐ Donation 5 ☐ Other (Specify)	emovali from State)	ch 13 0	4 R	rentwoo	od Md
Baltimore,	permit. Pages Department of P Important: If its any injury or of		21. Signature of Funer Service Liounse				ddress of Facility			renewoo	od ma.
Ö	Depar Impor		Frome S.	sound				. NW Wa		DC 200	11
п			23a. Part Enter the disease or complication, or heart failure. List only on	carlous that ceused the leat e cause on each line	h. Do not ent	er the mode of	dying, such as care	diac or respiratory a	rrest,		Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	HYPO VOLEMI							Onset and Death
Н	/Medical Examiner		resulting in death)	Due to (or as a conseq		0-0.	TONEUM				
В	LXdillillei	Ļ	Sequentially list conditions, if any, leading to immediate	BLEEDING Due to (or as a conseq	INTO	161	TONEUM				
	pet 11sit	nine	cause. Enter Underlying Cause (Disease or injury	AUTOCOAGE		bN		`		ļ	- 1
	be executed sician and burial-transif	Examine	that initiated events cresulting in death) Last	Due to (or as a consec	uence of):						
8760,	cate be executed by sician and the burial-transit			MITRAL V	ALVE	KEPLI	ACEMEN-	T			
9	death certificate e attending phys d for use as the	Physician/Medical									
Вох	Jeath certifica attending ph d for use as th	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregn	ancy		2	3d. Date of delive Month	
	ne deal the att	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of d 9☐ Unknown		Other (specif				MORITI	Day Year
P.0	ac o	Phy	9 ☐ Unknown Part II. Other significant conditions con	tributing to death but not rec	ulting in the u	ndarhing caus	o awan in Part I	23e Did t	obacco u	se contribute to ti	ne cause of death?
	89 E 99	þ		ENAL DISEA		noenying caus	e given in raiti.		Yes 2		100
Ö	requ	etec	CARDIOMY OPATHY							24h Mara auta	new findings available
3ec	e la has	Completed	PONGESTIVE HE	ART FAILUR	6			- autor		prior to co death?	psy findings available impletion of cause of
a	ician: The l certificate ha rector, page		25. Was case referred to medical	TKILLUR			00 81		2 🗆 No	1 Yes	2)X No
Vital Records,		o Be	examiner?	lospitat:	ER/Outpatier	nt 3 DOA	Other	Death (Check only only only only only only only only		Other (Specif	iv)
of	Physer this eral di	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		Injury at Work?	28d. Describe			,,
ion	Attending I r death. ector: After by the funer	atlo	t Natural 5 ☐ Pending 2 ☐ Accident investigation	(Monus, Day real)	tnjury	М	1 ☐ Yes 2 ☐ No				
Division of	P S S	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		eet, factory, of	fice	28f. Location (d Number or Rura	al Route Number,
۵	itel or is afte rel Dir led in										
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in	Medical	29a, Certifier iX Certifying Physical (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ition and/or in	h occurred at the vestigation, in a	ne time, date and pl my opinion, death o	lace, and due to the occurred at the time,	cause(s) a date and	and manner as s place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	7 .		29c. Li	cense number		29d. Date	e signed (Month,	Day, Year)
^	- 310) two	has		1	60330	1	3	18/04	
1	(5)		30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type,	Print)	1.1/	P CHEVERLY,		/ - / - /	
1	-0					Print) DR	IVE	CHEVERLY	M	D 207	85
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1-2 2004	2. Registrar's Signa	ature	les		,			

DHMH 17 Rev 1/2001

Registrar

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2004

		1 - For State Registrar	State of Maryla	nd / Depa		of H	ealth ar	nd Mental	Hygie Reg	ene	004	09949
Physic /Medi			argaret	Lamm				2. Date Marc		<u> </u>	2004 4	3. Time of Death
Exami	ner	4a. Facility Name (If not institution, give 5802-F 01ive Court 5. Social Security Number 6. Sec	t	(o.c.t.b.inth.nto)		Fred	Location of erick		of Bireh			erick
Funeral Director			м 2⊊ғ 61	Yrs.	Months	Days		Min. Apri	1 16	(ear)	2 Caun	figinia
Maryland I-f ehow	tor	10a. State 10b. County Maryland Fred	erick 10c. C	ity, Town or Lo	ocation	Fr	ederio	ck			10	0d. Inside City Limits 1 TyYes 2 ☐ No
th with the 23a or 28a	ai Director	10e. Street and Number 5802-F Olive Cour	t		10f. Zip	Code	21	L703	10g		of What Coun	try?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked othat than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, if a Medical Evanties must be notified at any injury or other treumatic.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	Was Deced If Yes, spec		spanic Origin, Mexican, I	n? (Specify Yes Puerto Rican, etc	or No-		ace - America lack, White, e cify: Wh	
Baltimore, Maryland 21215-0035 permit. Pages I and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: if Item 27 I e marked other than "natural", or any injury or other treumatic event, if a Medical Exert proces.	Completed	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i> College (1-4or 5+)	(Give	dent's Usual kind of won DO NOT us MAKET	l Occupa k done di e retired)	tion uring most o	of working	16		Business/Ind	
yland Z buld be filed Mental Hygi srkad other	To Be C	17. Father's Name (First, Middle, Last) Forrest B. Payn	e, Sr.]	s Name (First, M [va Cost	ello	iden Suma	ame)	
, Mar, and 2 sho saith and n 27 le m		19a. Informant's Name/Relationship (Ty Robert Lee Lamm,	Sr./Husband	58	02 - F (Oliv	e Cour	or Rural Route No.	eric	k, MD	21703	3
Pages 1 nent of He nent: If Iten ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)					1	cch 26,	18			wn, State Irg, MD
Balt permit. Departr Imports any infr		21. Signature of Funeral Service Licens 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complete	BA 1 Lando	1021 ²²	Name and Keene	Address By all Fast	of Facility nd Bas Churc	ford Fu	nera t F	l Hom	ne rick M	Ф 21701 —
ate be executed Wedical Examiner Wasicien and he burial-transit	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consection of the consection of	quence of):		_		ONALY				Approximate Interval Between Onset and Death
Box 68 e death certifice the attending pl sed for use as t	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	aldeath 3	Ectopic pre						Date of deliver	ry Day Year
rdS, P.C. quires that th n signed by t	d by P	Part II. Other significant conditions con Steroid Induce		_	nderlying ca	luse give	n in Part I.		Did tobac	2 No		e cause of death? ably 4 Dunknown
II KECOrd The law requir tate has been si page 2 should	Complete								Was an autopsy performe	- 1	were autop prior to con death? 1 \(\subseteq \text{Yes} \)	esy findings available apletion of cause of
UNISION OF VITAL HECORDS, To the Hospitel or Attending Physician: The law requires t within 24 hours after death. To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be (tion; To Be	25. Was case referred to medical examiner? 1	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury		3c. Injury Work	r: 4 ☐ Nursi	f Death (Check of the check of	Residenc)
UIVISI al or Atten after dea l Director d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, lactory,	office	C 7 6 11		on (Stree r Town, S		nber or Rural	Route Number,
Lothe Hospitel within 24 hours a Tothe Funeral I completely filled	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signals eand title of certifier 29c. License number							place, and due to occurred at the t	the caus	se(s) and n and place	nanner as sta , and due to	ated. the cause(s)
To th withir To th comp	Me	29b. Signal Pand title of certifier	An)		License D35	number 5164			•	26, 20	
5		30. Name and address of person who de Andrew Zarick. 31. Date filed (Month, Day, Year)		15 West		nth	Stree	t, Frede	rick	, MD	21701	
St Regist	ate rar	31. Date filed (Month, Day, Year)	1 2004		17538	Sala B	7					

			1 - For State Registrar	State of Marylan	nd / Dep			lental Hyg	~ ~	04 119950
	Physici /Medic		Decedent's Name (First, Middle, Last, JOHN DA	LTON LUCAS				2. Date of Deat Month MAR	Day 2004	yeer 4 6:29 M
	Examir Funeral Director		4e. Facility Name (If not institution, give NATIONAL NAVAL 5. Social Security Number 443-10-9906	MEDICAL CENTE			THESDA If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct.3,1	4c. County o	
21215-0036	a within 72 hours after death with the Maryland Jione. I than "natural", or itams 23a or 28a-f show The Medical Examanar must be confibed at	by Funeral Direc	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Ar 10e. Street and Number 1001 Jigger Co 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	10c. Cit	16a. Dece	10f. Zip Code 2146 Was Decedent of II Yes, specify Cub	Hispanic Origin? (Spran, Mexican, Puerto Specity:	acify Yes or No- Rican, etc.)	USA 14. Race Black	10d. Inside City Limits 1 □ Yes 2√2 No nal Country? - American Indian, White, etc. White
and 21215	be filed ntal Hygi od other event, I	Be Completed	(Specify only highest grad Elementary/Secondary (0·12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 5+		kind of work done DO NOT use retire Civil Ser	18. Mother's Name	(First, Middle, M	faiden Sumame	Government
e, Maryland	s 1 and 2 should I f Health and Men Item 27 ie marke other traumatic	To	19a. Informant's Name/Relationship (Ty	s, son	1001	-	and Number or Rura Court Ann	napolis,N	City or Town, S. lary land	1 21401
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra page.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundation Service Licens	lemoval from State Ar	emetery, crer lingtor	natory or other pla n Nation of 2. Name and Addre	nICem. 04/	08/04 . Town I	Arlingto Funeral	n, Virginia Choices ,Va. 22307
\$t'.	Physician /Medical Examiner	Examiner	23a. Part. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last	ne cause on each line.	RY ART uence of):		ng, such as cardiac c			Approximate Interval Between Onset and Death
.O. Box 68760,	death certific e attending pl d for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1	Ideath 3	Ectopic pregnanc	/		23d. Date Month	-
Records, P	requires been sign should be	by	Part II. Other significant conditions con	stributing to death but not resi	ulting in the u	nderlying cause giv	en in Part I.		s 2 X No 3	ute to the cause of death? Probably 4 [Unknown]
Vital Re		Be Completed	25. Was case referred to medical examiner?				26. Place of Death	autopsy perform 1 Yes 2	ed? pric	re autopsy findings available or to completion of cause of ath? Yes 2 No
Division of \	tending Physical Partics tor: After this the funeral direction	Certification; To	1 Yes 2 No 27. Manner of Death 11 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At hobuilding, etc. (Specific	ER/Outpatien 28b. Time of Injury ome, larm, stre y)	28c. Injur Wor M 1 🗀	y at k? Yes 2 \Bo	ne 5 Resider 28d. Describe how 28f. Location (Stree City or Town,	v injury occurred	
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Ce	29a. Certifier Check only one) Certifying Phys	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death tion and/or inv	n occurred at the tire restigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, dat	use(s) and mann te and place, and	er as stated. I due to the cause(s)
)	To the Within To the Comp	Me	29b. Signature and lille of certifler	Jankons)	29c. Licens 01012	e number 33170 (VA		d. Date signed ($03/08$	Month, Day, Year)
83	Sta	te	30. Name and address of person who co JANINE R. DANKO 31. Date filed (Month, Day, Year)	LT MC USN 32. Registrar's Signa	R		ATIONAL NA ETHESDA MI			TER

			1 - For State Registrar MEND#23a(a,b	State of M	Maryland / Dep	artment of H	lealth a	-	giene Reg. No. 20	NL DOOF
			Decedent's Name (First, Middle, L.	st)	OH, III WILDO			2. Date of Dea	ath	3. Time of Death
3	Physici /Medi	cal	Josephine Ma					March 8	3 2004	12:40 P ^M
	Examir	ner	4a. Fecility Name (If not institution, gi		or)	4b. City, Town, o		Death	4c. County of	
			Brooke Grove Nurs 5. Social Security Number 6.		Age (In yrs. last birthday)		ney If Under 2	4 Hrs. 8. Date of Birt		tgomery
	Funeral Director			1□M 2 X F	93 Yrs.	Months Days	Hours	Min. (Month, Da)	v, Year)	Birthplece (State or Foreign Country)
	ט		Usual Residence of Decedent		7.5		1	march .	10,1910	West Virginia
	urylan show		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Ba-f s	Director	Maryland Montgom	ery	Silver S	pring				1 ☐ Yes 2 🕅 No
	with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	a 23		2813 Village Lane			20906			U.S.A	
	Item Item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Force 1 Yes 2	s?	Was Decedent of H If Yes, specify Cuba	lispanic Origi an, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)		American Indian, Vhite, etc.
336	urs af	by	37€ Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 🎾 No	Specify:		Specify:	White
Ö	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or teme 23e or 28e-f show ent, the Medical Examinar cust be notified at	Completed by	15. Decedent's E		16a. Dece	dent's Usual Occup	ation		16b. Kind of Busin	ess/Industry
215	thin 7	nple	(Specify only highest gr Elementary/Secondary (0-12)	College (1-40	lite	kind of work done of DO NOT use retired	during most o d)	of working		
7	ed wi	Con	12			memaker			70	vn Home
lud	d off	Be	17. Father's Name (First, Middle, Las)				s Neme (First, Middle,		
<u> </u>	ouid Men Parka	P	Mario Crisafulli					a Bongiorno		
Maryland 21215-0036	12 sh h and h and lis m		19a. Informant's Name/Relationship (Bruce Muscolino -					or Rural Route Number		
e)	1 and Health		20a. Method of Disposition	2011	The State of the S			Silver Spr		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interportant: If item 27 is marked other than "natural", or itema 23e or 28e-f show any injury or other treumatic avent, the Medical Experient must be notified at ORCE.		1 Burial 2 □ Cremation 3 □		20b. Place of Dispo cemetery, cren				20c. Location - City	
	artme artant ortant injury		*4 ☐ Donation 5 ☐ Other (Speci 21 Signature of Funeral Service Lice		Woodlawn				Wadsworth	
Ba	Departing of the sany once	l li	Dullone	luxon	1	1800 New	Hampsh	nire Av., S	ilver Spi	al Home, Inc.
	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one gausezon each	od the death. Do not ent line. Con 1 Gand.		g, such as ca ath	irdiac or respiratory arr	est,	Approximate Interval Between Onset and Death 7 days
	/Medical		disease or condition resulting in death)	a	s a consequence of):					/ days
ij.	Examiner				e Renal F	ailure				
	D =	ner	Sequential Vist conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence of):					
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
60,	cian a	ũ	resulting in death) Last	Due to (or a	s a consequence of):					
8760	ficate be execute physician and is the burial-trans	dical		d						
×	requires that the death certificate be executed then signed by the attending physician and hould be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcom	e of pregnancy		-			
Box	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
o.	the d y the tched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at time of death 3	Other (specify)				
7.	w requires that the dibent signed by the should be detached	by Pt	Part II. Other significant conditions of	ontributing to death	but not resulting in the un	iderlying cause give	en in Part I.	23e. Did tot	acco use contribut	to the cause of death?
Hecords,	quire; n sign	d b	Hypertension, Po	lymyalgia	Rheumatica			1 □ Y€	s 2 ∑ No 3 □	Probably 4 Unknown
ပ္သ	3 -0 0	ompieted						24a. Was a	n 24b Were	autopsy findings available
	ician: The la certificate has rector, page 2	mo						autops perform	y prior ned? death	to completion of cause of
	an: rtifica tor, p	e C	25. Was case referred to medical				26 Place of	1 ☐ Yes 2	X□No 1□Y	es 2 No
>	Physician: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ient 2 ER/Outpatient	3□ DOA Othe		ng Home 5 ☐ Reside	11	nacifu)
0	ng Ph ter th		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inj (Month, D	ury 28b. Time of	28c. Injury Work			w injury occurred	Decity)
<u>0</u>	endir eath. or: Al	atic	2 Accident investigation	1	-,		res 2 □ No			
DIVISION	or Att after d Direct in by t	Certification:	3 Suicide 6 Could not be determined	286. Place of in	njury - At home, farm, stre tc. (Specify)	et, factory, office		28f. Location (Str City or Town	reet and Number or , State)	Rural Route Number,
	pital Durs a eral filled		29a. Certifier 1/X Certifying Ph	veicias. To the hear						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	(Check only 2 Medical Exam	niner: On the basis and manner s	t of my knowledge, death of examination and/or inv tated.	estigation, in my op	e, date and p pinion, death o	place, and due to the ca poccurred at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	Tot	Σ	29b. Signature and title of certifier			29c. License			d. Date signed (Mo	
			+ Clen	my	2	D3.	5045	Man	rch 8, 20	04
,	>		30. Name and address of person who			•				
			Philip G. Henjur		3416 Olandwo	od Court	#204,	Olney, MD	20832	
	Stat Registra	-	31. Date filed (Month, Day, Year) MAR 1 5 200		rar's Signature	Son de				

				State of Ma									gible.			
		•	1 - For State Registrar		,		tificate					eg. No. 2	00	L	09952	2
			1. Decedent's Name (First, Middle, L								Date of Deat Month	h Day	Yeer		Time of Death	-
	Physicia /Medic		WALTER MOY	ζER							ARCH 1	0, 20	04		3:26A M	_
	Examin	_	4a. Facility Name (If not institution, ga	ive street and number)			4b. City, To	own, or L	ocation of De	eath			unty of Dea			
			MONTGOMERY GENER			bint aland	OLNE		If Under 24 H	Hrs o	Date of Birth		TGOME		(State or Foreign	
	Funeral		,	Sex 7. Age 1 □ M 2 □ F	i (In yrs. last 85	Yrs.	Months [Ain.	(Month, Day,	Year)		OU <i>ntry)</i>	(State or Foreign	
	Director		577-22-1084 Usual Residence of Decedent							API	XIL D,	1910	IMP	INIL.	AND	_
	ylanc		10a. State 10b. County		10c. City, T	own or Loc	cation								nside City Limits	
	Ba-f •	ctol	MARYLAND MONTGO	OMERY	SIL	VER S	SPRING	T							I XYes 2 No	
	4 P	Director	10e. Street and Number				10f. Zip Co					0g. Citizen				
	s 23s		14514 HOMECRES	ROAD, L-		12 1		0906		2 /Specify			STATE Race - Am		F AMERIC	<u>A</u>
	Item Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		IS. If	Yes, specify	y Cuban	panic Origin? , Mexican, Pu	uerto Rica	an, etc.)		Black, Whi		raidi,	
99	urs af	by	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	ARMY WWII		☐ Yes 2☐	XNo	Specify:			Sp	ecify: [TIHV	E	
Ď	72 hours after death with the Marylan *naturet' or Items 23e or 28e-f ehow idical Examinational to indiffed at	Completed	15. Decedent's l			6a Deced	lent's Usual (Occupat	tion uring most of	workina		16b. Kind	of Business	s/Indust	у	
7	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)				OWNER			ВПΥ	RMACY	7		
2	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other than "naturel", or items 23a or 28a-f ehow event, the Madical Examinations use to indiffud at	CO	17. Father's Name (First, Middle, Las			ГПАІ	MAGIS		18. Mother's I	Nama /Fi	inst Middle I			L		
and	d la d	Be	NATHAN MON						SARAI			Walder Sar	namo)			
Ž	2 should be filed and Mental Hygi Is marked other aumatic event, I	ဥ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (S	Street ar	nd Number or	r Rural Ro	oute Number	City or To	wn, State,	Zip Cod	fe)	_
<u>8</u>	od 2 state ar trau		NEIL E. MOYER - S	SON	7	723	LVYMOU	INT :	TERRACI	E, P(ОТОМАС	, MD	20854	' +		
ē,	of Head		20a. Method of Disposition		20b. Place	e of Dispos	sition (Name natory or othe	of er place	,	Date		20c. Locati	on - City o	r Town,	State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once.		1 🖾 Burial 2 □ Cremation 3 1 □ Cremation 3 □ Other (Special Control of Con		i i				ERY 03	/12/0	04	ADEL	PHI,	MAR	YLAND	
a	permit. Departn Imports any inju		21. Signature of Fusieral Service Lic	ensee			Name and			DC MI	PMODE A	T CHA	DET	TNC	7	
	80 = 20			h					ILLE				MD 2			
			23a. Part1. Ever the disease, or co shock or heart failure. List on		-					diac or re	spiratory arr	est,		Inte	oroximate erval Between set and Death	
ı	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Scitem			MYUP	A711	4							_
	Examiner			Due to (or as a	a consequen	ice of):	DE P	Dace	marro) INC	PATION	Sizi	, man			
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as			01-1	1100	I to the least	4 11 -						
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Conbi	ESTIVE	HEA	er FA	المنساء	RE							Ų
60,	te be executed ysicien and te burial-transit	Exa	resulting in death) Last	Due to (or as												
_	ate be hysici ihe bu	licai		STAPI	4 256	71661	Mill									_
x 68	ires that the death certificat signed by the attending phy d be detached for use as th	Completed by Physician/Medi	IF FEMALE:	23c. If yes, outcome	of preparation	,							5 / .			
Вох	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal de	ath 3	Ectopic preg					230.	. Date of de Month	elivery Day	Year	
P.O.	the de	iysic	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown		. 0	Girlor (open	J., J.								
<u></u>	s that ned b	y Pł	Part II. Other significant conditions	-		-		ıse giver	n in Part I.		23e. Did tol	oacco use	contribute f	to the ca	use of death?	
rds	quire; en sig uld ba	ed b	CHRUNIC OBS	TRUCTURE LU	Nr Di	sease	ر			-	1 🗆 Ye	es 2□N	o 3 🗆 P	Probably	4-Unknown	
006	aw requir is been si 2 should	piet	ity pertension	m							24a. Was a autops	n 2	4b. Were a	utopsy	findings available	
Division of Vital Records,	The larate has	E O	HISTORY OF	VENTRICUL	ar TA	CHYCA	ROIA				perform	ned?	death?	s 2		
ita	Physician: this certific ral director,	Be (25. Was case referred to medical examiner?						26. Place of	Death (C	hack only on	e)				Ī
5	shysic this c	2	1 Yes 2 No		nt 2 ER				4 Nursin		5 Reside			ecify)		_
N C	Jing F	lon	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day	Year)	Bb. Time of Injury	M 280	C. Injury	at ? es 2 □ No	280	Describe ho	ow injury oc	curred			
Sic	death ctor: y the	ficat	2 Accident investigat 3 Suicide 6 Could not	t ho	ury - At home	e, farm, stre				28f.	Location (St	reet and N	umber or F	Ru <i>ral R</i> o	ute Number,	
<u>></u>	after after Dire	Certification:	4 Homicide determine	ed 28e. Place of Inju- building, etc	c. (Specify)						City or Town					
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying	Physician: To the best	of my knowle	dge, death	occurred at	the time	e, date and pl	lace, and	due to the c	ause(s) end	manner a	s stated	ļ.	_
	n 24 i he Fu pletely	Medical	(Check only 2 Medical Ex	taminer: On the basis of and manner sta		and/or inv	estigation, in	n my opi	inion, death o	occurred a	it the time, d	ate and pla	ce, and du	e to the	cause(s)	
	To t To th	Σ	29b. Signature and title of certifier	Linguan	m	>		License				9d. Date si				
•	5		▶ Wallet W.	w your !			!)	000	フン			IIM	•			
			30. Name and address of person wh					Da	VIO 111.	Fin	(u) Can	181	09 PF	RINC	E PHILIP 20832	
		ıte.	MUNTOUTH 31. Date filed (Month, Day, Year)	32. Registra				uls	, , w	1 6017	003010	-0	LNEY,	, MD	20832	
	Sta Regist		MAR 15	2004 Sen	ar's Signature	D	000	reks	1							

			1 - For State Registrar	State of Ma		/ Depa		Health a	and Mer	ntal Hygie	ne 🧸	104	0005
			Decedent's Name (First, Middle, Last	1)						Reg. Date of Death	140	04	3. Time of Death
ı	Physici		Julia Ailee	en.	McM	urrou	αh			Month arch 12,		Year	2:10 a M
A	/Medic Examin		4a. Facility Name (If not institution, give		TICIT	arrou	4b. City, Town,	or Location o		1	4c. County of	of Death	2:10 4
- ž.		٠.	4910 Strathmore A	laronuo			Vanadaa						
	Funeral		Social Security Number 6. Se	x 7. Age	e (In yrs. las	st birthday)	Kensing If Under 1 Year	If Under 2	24 Hrs. 8.	Date of Birth	Montg	Omer 9. Birthp	y lace (State or Foreign try)
	Director		214-54-5786	☐M 254F	67	Yrs.	Months Days	Hours		(Month, Day, Ye			nsylvania
	pr ,		Usual Residence of Decedent							301			IIS Y I VAII LA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show ery injury, or other treumatic event, the Madical Examinaria using the natified at once.		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	9 Mg	Director	Maryland Montgo	mery	K	ensin	gton						1 ☐ Yes 2 ☑ No
	or 26	Olre	10e. Street and Number	J			10f. Zip Code			10g.	Citizen of W	hat Coun	try?
	23a		4910 Strathmore Av	enue			20	895			USA		
	sme sms	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Decedent of t f Yes, specify Cub		gin? (Specify	Yes or No-	14. Race	- Americ	an Indian,
Ď	or it	F	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 ☐ N If Yes, Give	No		1 ☐ Yes 2 🔯 No		, i dono i nob	111, 610.7		, WINITE, C	etc.
Š	aours aral',	d b	3 Widowed 4 Divorced	Year or Dates:			2410				Specify:	Wh	ite
0500-61717	72 P	Completed by	15. Decedent's Edu (Specify only highest grad			(Give	lent's Usual Occup kind of work done	during most	of working	16b.	. Kind of Bus	iness/Inc	lustry
V	Athin hen hen	d .	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. I	OO NOT use retire	id)	•	Ca	tholic	· Fd.	unstion/
V	filed w Hygiel other ti	CO		4		Teach	er/Socia						ucation/ rvice
2	be fill H d ott	Be	17. Father's Name (First, Middle, Last)					18. Mother	r's Name <i>(Fir</i>	rst, Middle, Maid	en Sumame)	
Maryland	ould be Mental arkad o atic eve	2	John Owen McMurrou	gh				Joh	anna	Carey			
0	2 sh and is m	1	19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	g Address (Street	and Number	r or Rural Ro	ute Number, City	y or Town, S	tate, Zip	Code)
	and ealth n 27		Patricia Vandenber	g,C.S.C.		412 E	ast Frank	klin A	venue	Silver	Sprin	w Mi	20901
ב	of H		20a. Method of Disposition 1 ဩBurial 2 ☐ Cremation 3 ☐ F	Computal from State	20b. Plac	e of Dispo	sition (Name of	ce)	Date	20c.	Location - C	ity or Tov	wn, State
Ĕ	Pages nent of ant: If it		'4 □Donation 5 □Other (Specify)		Gate	ot H	eaven netery	!	ion 15	2007 64	1,,,,,,		
baltillore,	permit. Page Department (Importent: If eny injury or once.		21. Signature of Funeral Service Licens	00		22	Name and Addre	ess of Facility	/				g,Marylan
ם	90E 9	- //3	Tru S.	Scenta	7	Fr	ancis J. D Univers	Colli	ns Fun	eral Ho	me, Ir	ic.	m 00001
н			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused	the death.	Do not ente	er the mode of dyir	ng, such as c	cardiac or res	piratory arrest.	r Spri	ng, N	1D 20901 Approximate
			Immediate Cause (Final										Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Atherosc	lerot:	ic Co	ronary Va	ascula	r Dise	ase			ears
	Examiner		-	Due to (or as a	a consequer	nce of):							
	g5345	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Oue to (or as a	CONSEQUE	ice of						_	
	ted nsit	듄	cause. Enter Underlying Cause (Disease or injury	000 10 (01 00 0	COMBETTE	100 01).							
	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a	consequer	oce of):							
	pa picie	calE				.55 51).							
0	phys the			t.									
<	death certificat e attending phy d for use as the	Physician/Med	IF FEMALE:	0-14					0.1				
	ath c	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome o 1□Live birth 2	2 Fetal de	ath 3 🗆	Ectopic pregnancy	,			23d. Date		,
	the a	S	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	time of deat	h 5□	Other (specify)				Month) [Day Year
	that the de led by the a detached f	F.											
ń	gne gne	þ	Part II. Other significant conditions con	tributing to death but	it not resultir	ng in the un	derlying cause giv	en in Part I.	, i	23e. Did tobacco	use contrib	ute to the	cause of death?
2	w requir been si should I	ed								1 Yes	2 🔯 No 3	☐ Proba	bly 4 □Unknown
	2 0 0	ompleted							- 2	24a. Was an	24b. We	re autops	sy findings available
	The I	E o								autopsy performed?	prid	or to com ath?	pletion of cause of
	42 CT	O	25. Was case referred to medical					OC Diana		☐ Yes 2 N	lo 1 L	Yes 2	!L No
-	Physicien: this certific al director,	0	examiner?	lospital:	* 2 CEP	/Outpatient	20 DOA Oth			eck only one)	. 70		
	tending Phys death. tor: After this (- 1	27. Manner of Death	1		b. Time of	3LI DOA	4 U Nurs		5 ☑ Residence Describe how inj			
	ding h. Afte	Ę.	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	Injury	28c. Injun Wari M 1	k?" Yes 2.⊟No		20301100 1104 111	dry occurred		
2	Attending r death. ector: After by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of Injur	nr. At home	form atta		103 2 110		anation (Ctores			
	or A after Dire	팊	4 Homicide determined	building, etc.	(Specify)	i, iaiii, stie	et, ractory, office		281. L	ocation (Street a Sity or Town, Sta	te)	or Hurai i	Houte Number,
1	ors a		00- C						1				
	To the Hospitel or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	edical	29a. Certifier 1 💢 Certifying Phys (Check only one)	sician: To the best of ner: On the basis of e	examination	dge, death and/or invi	occurred at the time estigation, in my of	ne, date and pinion, death	place, and d occurred at	ue to the cause(the time, date ar	s) and mann nd place, and	er as stat	ted. he cause(s)
	the the	Med	29b. Signature and title of certifier	and manner state	ed.								
	Z N N N		250. Signature and title of Certifier	SEL.			29c. License	e number		29d. D.	ate signed (/	Month, Di	ay, Year)
	1		Mance	7 (D 340	32		Marc	h 12,	200/	,
	7		30. Name and address of person who co	mpleted cause of dea	ath (Item 23	a) (Type, F				· · · · · · · · · · · · · · · · · · ·		<u> </u>	•
			Jeanne Asher, M.D.	10301	Georg	ia Av	enue #20	3 Sil	ver Sr	ring.Ma	ryland	_200	902
	Stat	_	31. Date filed (Month, Day, Year)	32. Registrar	r's Signature	19	Spark			-0 7	J		· •
	Registra	-	### F T C 200	THE THINK	PH	Post	The state of the s	age.					

0.400.000.000		1 - For State Registrar	State of Marylar	nd / Depa		ealth and N	Mental Hygie	ne 2001	0995
Physic /Med	cal	Decedent's Name (First, Middle, Last	Rosalind			IMONT	2. Date of Death Month March 15	Day Yeer	3. Time of Death 7:51 A M
Exami Funeral Director		4a. Facility Name (If not institution, give Holy Cross Hospit 5. Social Security Number 6. Se 137-14-1576	a1 7. Age (In yrs.	V		Spring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	Montgome 9. Birtl Co	
D	or	Usual Residence of Decedent 10a. State 10b. County Maryland Montgom		ity, Town or Lo	cation r Spring		Feb. 3, 1	921 New	York 10d. Inside City Limits 1 □ Yes 2 ☑ No
ath with the N 23a or 28a-	Funeral Director	10e. Street and Number 11512 Yates Street			10f. Zip Code 20	902	Un	Citizen of What Co	untry?
(1213-50035) within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show he Modral Ex. "uther!" wat be notified at	d by Fune	11. Marital Status 1 □ Never Married 2 ☼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cubar I □ Yes 2 ▼No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	rican Indian,
D D D	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give life. L	lent's Usual Occupa kind of work done di DO NOT use retired)	uring most of work	Na	.Kind of Business/I tional In ience (NI	stitute of
Maryland of 2 should be flik lih and Mental Hy 27 is marked oth traumatic svent	To Be (17. Father's Name (First, Middle, Last) Henry Brownstone 19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailin		Sopl	e (First, Middle, Maid nia Shapir al Route Number, Cit	den Sumame) a	7.
ages 1 and 2 nt of Health a II: if item 27 is		Martin Marimont, Hu 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	11512 Place of Disposemetery, crem	Yates St. sition (Name of natory or other place	o, Silver	Spring,		
permit. Pages 1 a Department of Hee Important: if item any injury or othe		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furiera (ervice)		Tc	emorial Ga Name and Address orchinsky	of Facility Hebrew F	uneral Ho		20010
Physician /Medical Examiner		23a. Part I Prove the disease, or complishock, or care failure. List only or Immediate Cause (Final disease or condition resulting in death)	Acute Myoca	ardial			Prespiratory arrest	con, DC	20012 Approximate Interval Between Onset and Death
ate be executed hysician and the buriat-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Acute Strol Due to (or as a conseq Hypertensic	uence of): on					
death certific e attending pi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 🔲	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
hat ad b	by	Part II. Other significant conditions con	tributing to death but not resi	ulting in the un	derlying cause given	n in Part I.	23e. Did tobacci	o use contribute to t 2 ⊠No 3 ☐ Prot	he cause of death?
	e Completed	25. Was case referred to medical				00 81	24a. Was an autopsy performed?	prior to co death?	opsy findings available impletion of cause of
ling Phys	sation; To B	examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 12 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	3☐ DOA Other: 28c. Injury a Work?	at Pursing Hor	ne 5 Residence 28d. Describe how in		(y)
Hospital or Attending 14 hours after death. Funeral Director; Afte	ai Certification;	3 Suicide 4 Homicide 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At he building, etc. (Specify ician: To the best of my known of the basis of examination of examination of the basis of examination of examination of examination of examinatio	// wledge_death	occurred at the time	date and place of	28f. Location (Street and City or Town, Sta	ite)	
To the Hospital or within 24 hours after of To the Euneral Dire completely filled in b	Medical	(Check only one) 2 ☐ Medical Examinations) 29b. Signature and title of certifier 30. Name and address of person who con	and manner stated.	non and/or mye	29c. License r	number	29d. D	ate signed (Month,	the cause(s)
Sta Registr		Nagi Kanwaljit, M. 31 Date filed (Month, Day, Year) MAR 17 200	D., 1500 Fore	st Gler			ing, MD	20910	

		•	For State Registrar	State of M		partment of ertificate of		nd Mental Hyg	giene 200	4 09955
	Physicia		1. Decedent's Name (First, Middle, Last) James B. Martin					2. Date of Dea Month 3-11-0	Day Year	3. Time of Death 10:55 P. M
186 186 188	/Medic Examin	N 41	4a. Facility Name (If not institution, give s	street and number)	4b. City, Town	n, or Location of I		4c. County of Deat	
		Ш	Prince George's I			Cheve	rly ear If Under 24	Hre a Day (Dia	Prince Ge	
· Contraction	Funeral Director		220-40-6182	M 2 TE	ge (In yrs. last birthda 61 Yrs.	Months Da		Min. 8. Date of Birt (Month, Da) 1-10-4	y, Year) Co	hplace (State or Foreign untry)
	e Maryland 8a-f show	ctor	Usual Residence of Decedent		10c. City, Town or Owings					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with th	Dire	10e. Street and Number	.1		10f. Zip Cod			10g. Citizen of What Co	untry?
98	or items 23	y Funeral Director	1 Never Married 2 Married	12. Was Decedent Armed Forces 1 X Yes 2 I	No 6165			n? (Specify Yes or No- Puerto Rican, etc.)		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Modical Examiner must be notified at once.	Completed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: cation a completed) College (1-4or	16a. De (Gi	cedent's Usual Oc ve kind of work do b. DO NOT use re	cupation one during most of	of working	16b. Kind of Business/	Industry
2	led wi lygien her th	Con	47 Fabrica Name (First Middle Legs)	4	Fie	1d Engin		s Name (First, Middle,	Telephone	
Maryland	wild be fil Mental H nrked ott	To Be	17. Father's Name (First, Middle, Last) James B. Martin				Ann	ie Lee Eatı	mon	
Man	2 sho		19a. Informant's Name/Relationship (Ty						er, City or Town, State, 2	Zip Code)
Baltimore, I	les 1 and of Health if item 27 of other t		Barbara Martin-Stu 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ P		20b. Place of Dis	position (Name of rematory or other	1	keville, M	20c. Location - City or	Town, State
Ħ,	artment ortant:		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		Loundor	n Park Cr		-18-04	Baltimore, inaldi F. H	
Ba	Depril		I eluane a	Cude	lu :	11800 Nev	v Hampsh	ire Ave. S	ilver Sprin	g, MD 20904
8760,	Physician Pe executed Pe and Italicate Pe executed Physician and Personal Italicate Personal Italicate Personal	Jicai Examiner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a Due to (or a		GASTRO.	INTEST. FAILU	INAL B	1	Interval Between Onset and Death
.O. Box 6	death certific e attending p od for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death	3 □Ectopic pregna 5 □ Other (specify			23d. Date of del Month	ivery Day Year
<u>α</u>	Se Co	þ	Part II. Other significant conditions con	ntributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Il Records,	The law ate has b page 2 s	Completed							osy prior to death?	itopsy findings available completion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:			Othor	f Death (Check only o		AT OLD SUIS
of	ling After	tlon: To	1 Yes No ' 27. Manner of Death Statural 5 Pending 2 Accident investigation	28a. Date of In (Month, D	ury 28b. Time	of 28c. I	niury at Work? 1 Yes 2 No	28d. Describe h	dence 6 Other (Spec now injury occurred	cify)
Division	25 = -	Certification:	3 Suicide 6 Could not be 4 Homicide determined		njury - At home, farm, etc. <i>(Specily)</i>	street, factory, off	ice	28f. Location (5 City or Ton	Street and Number or Ru vn. State)	ıral Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledicai (of examination and/or				cause(s) and manner as date and place, and due	
	To th withir To th comp	Me	29b. Signature and title of certifier	1		29c. Lic	ense number		29d. Date signed (Monti	h, Day, Year)
•)	2 ech	_		00537	03	3/11/0	4
	10		30. Name and address of person who con Tsion Berhane M.I				zerla M	D 20785		
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature			Z0103		
	Regist		MAR 1 5 200	34 Jan	we &	Span	EN			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) Month Day March 15, 2004 2:15P M MATTHEWS WILLIAM CLARENCE 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplec Country, Sept. 7, 1951 Wash, 9. Birthplece (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours Min 1**X**M 2□ F 52 215-56-4322 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No MONTGOMERY Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 U.S.A. 1611 April Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 XYes 2 No 1951-If Yes, Give Year or Dates: 1972 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Road Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ε. Thelma Washington Frank Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) April Lane Silver Spring, MD 20904 Frank Matthews - Father 1611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, MD MD Veterans Cem 3/24/2004 * 4 Deponation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee R2. Name and Address of Facility Snowden Funeral Home, PA Washington St Rockville, MD20850 46 N Approximate Interval Between Onset and Death 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hearn-failure. List only one cause on each line, Immediate Cause (Final stramia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulling in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 3 Ectopic pregnancy Year 4☐Pregnant at time of death 5 Other (specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

item 27 is marked other than "neturel", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

Maryland 21215-0036

Baltimore.

Δ. that

of Vital Records,

Division

The law requires

or Attending Physician:

To the Hospitel

Pages 1 and 2 should be nent of Heelth and Mental

permit. Pages 1 and 2 s
Department of Heelth ar
important: If item 27 ie
eny injury or other trau

Completed by Funeral Director

Be

2

use as the burial-transit attending physician the 2 should be detached been signed by this certificete has раде funeral director. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Physician/Medical Examiner

Be Completed by

Medical Certification: To

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

31. Date filed (Month, Day, Year)

MAR

18

9 Unknown

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. Hemodechisis de End Stage Rena

24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 3 DOA 1 Yes 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 5 Pending

1 Natural 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 4 | Homicide

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Winhinghan DC 20032

29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a thitle of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Klame MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

March 16 2004 10055120

State Registrar

Richard Palmen mid 13 28 jouthern 32. Registrar's Signature

Juste 310 Avenue JE oaks

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) **Physician** MARCH 7, 2004 7:45 P **MEYERS** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number Days **Funeral** Months Hours 1 ☐ M 2 🖾 F 88 CANADÁ Director 102-01-7286 06/18/1915 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene important: if item 27 is marked other then "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examiner raist by notified as once. 1 TYes 2 □ No ROCKVILLE MONTGOMERY Director MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20852 6121 MONTROSE ROAD Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE 3 K Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JENNIE. MILLSTEIN JULIUS NOVIN ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10817 S. GLEN ROAD, POTOMAC, MARYLAND H. DAVID MEYERS/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MARCH 9, ROCKVILLE, MARYLAND PARKLAWN CEMETERY 2004 21. Signature of Funeral Service Lig 22. Name and Address DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

COF GOF GOF THROMBOSIS 20854 Approximate Interval Between Onset and Death **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off. Physician/Medical Examiner ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the a 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗆 Yes 212 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page certificate 1 ☐ Yes Division of Vital or Attending Physician: ector. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: Unursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: Alter Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D1808 NO. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. D. D. PATEL 6121 MONTROSE ROAD, ROCKVILLE, MARYLAND 20852 31. Date filed (Month, Day, Year) 32. Begistrar's Signature State MAR 1 5 2004 Valle. oaks Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1: 25AM Miller Lindser 03 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Maryland - Shock Trum Reltimore City University If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🕅 F Months 215-35-0196 17 03/07/1987 MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28e-f show any injury or other treumatic event, the Medical Examinating matter mouthed at 10a State 1 ☐ Yes 2 No **Funeral Director** MARYLAND MONTGOMERY N. POTOMAC 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 1 KEENELAND CT. 20878 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STUDENT HIGH SCHOOL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DAVID MILLER ပ DIANE ELIZABETH TURNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID MILLER/FATHER 1 KEENELAND CT., N. POTOMAC, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State `4 □Donation 5 XOther (Specify) NI CHE GARDEN OF REMEMBRANCE 03/14/2004 CLARKSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on which line. Approximate Interval Between Onset and Death Immediate Cause (Final Our disease Shick Due to (or as a consequence of): Physician 400 disease or condition resulting in death) /Medical dezs Examiner brach I varing tie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner AL WALINER or Attending Physician: The law requires that the death certificate be executed use as the burial-transit signed by the attending physician and d be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director. Be 26. Place of Death (Check only one) Hospital: 1 patient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 28a. ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural ~ 3'00 PM 1 ☐ Yes 2 No Motor while crash 03-04-04 2.Accident hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15209 SELECAL 4 Homicide Duilding, etc. (Specify)

City or Town, State) 15209 SENEIALUMD

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place. To the Hospital within 24 hours a To the Funeral C Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03-11-2004 AV4176035-15057 Kevot A. I. MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Maryland - Shock Truma Center University A 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAR 1 5 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 9:06 P M MARCH 11, 2004 MITTELBERG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY **BETHESDA** SUBURBAN HOSPTIAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 StF 577-07-8147 86 01/25/1918 WASHINGTON, DC Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show rei", or items 23a or 28a-f ehov Examiner must be notified at SILVER SPRING 1 Tyes 2 TNo MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20902 U.S.A. 11125 NORLEE DRIVE Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "naturel", or Ite urg or other traumatic event, the Mutical Examine 1 ☐ Yes 2 X No 1 Never Married 2 Married WHITE 21215-0036 1 ☐ Yes 2 🗓 No Yes, Give Specify: Specify: þ 3 X Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTY SALON 12 BUSINESS OWNER 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last, Be FANNIE SEIGEL PHILLIP GINDES 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2087819a. Informant's Name/Relationship (Type, Print) 12605 BLUE MOUNTAIN COURT, DARNESTOWN, MARYLAND SALLY GOLDMAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a Method of Disposition Department of H
Important: If its
any injury or ot
once 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 3/14/2004 FALLS CHURCH, VIRGINIA 4 □ Donation 5 □ Other (Specify) KING DAVID MEMORIAL 21. Signature of Fundal DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. (A) (NO) 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part 1. Enter the discass, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Shours resulting in death) /Medical Due to (or as a consequence of) **Examiner** EGVS rial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending f IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) o the detached 9 Unknown 9 Unknown ģ ۵. signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) · Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Impatient 2 2 ER/OutpatienI 3 DOA o after death.

Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Division 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö a Funeral Dietely filled in To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 56476 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tela mD 10 Center Dr. 12 m 4403. Bethesck, mD 20892 UlioA-Cha 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 15 State 2004 souls! Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Z 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 3:29 2004 Mohamed Mar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Spring If Under 24 Hrs. Silver Holy Cross Hospital Montgomery Birthplace (State or Foreign Country) Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Min. Hours 1 M 2 □ F Days 77 Dec. 11.1926 Somali Director 220-27-5526 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10b. County or 28s-f show f Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23a or 28s-1 show other traumatic event, the Modical Examinational be notified at 1 Ves 2 □ No Gaithersburg Director Md. Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 7304 Damascus Rd. 20882 U.S.A. Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. Int: If item 27 is marked other then "natural", or item 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Somalian Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ali Mohamud Mohamed Ktubay Abdullah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 ie
any injury or other trau 7304 Damascus Rd., Gaithersburg, Md. Ahmed Mohamud/son 20882 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 3/13/04 Adelphi, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 20011 22. Name and Address of Facility Universal Mortuary 411 Kennedy St. N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 515 Physician /Medical ailune Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner moner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contrib ting to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۵ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 TYes certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3□ DOA 1 Yes 2 ER/Outpatient Medical Certification: To this After the 27. Marmer of Death

1 Natural

2 Accident Da e of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of completed cause of death (Item 23a) (Type, Print) Name and address of pe 6-1 no. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 15 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) \(\Omega\).

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Registrar

			1 - For State Registrar	State of Mary	rland / Dep <i>Ce</i>	artment of l	Health and I Death	Mental Hygie	ne 200L	09962
	Physici /Media		1. Decedent's Name (First, Middle, La Catherine	A		Moone		2. Date of Death Month March 13	Day Year • 2004	3. Time of Death 6:35 P M
	Examir	er	4a. Facility Name (If not institution, given Manor Care Roland St. Social Security Number 6.5	l Park	Lum foot hith do	4b. City, Town, Baltimo			4c. County of Death	
	Funeral Director			1 M 2	92 Yrs. last birthday)	Months Days		8. Date of Birth (Month, Day, Ye July 6,	ear) 9. Birth Cot 1911 Vi	place (State or Foreign, intry) rginia
	be filed within 72 hours after death with the Maryland tall Hygiene. I tall Hygiene the "natural", or Itams 23a or 28e-f show other then "natural", or Itams 23a or 28e-f show event. The Medical Examinat must be notified at	I Director	Maryland Howard 10e. Street and Number 7683 Blueberry H]	c. City, Town or Lo)		Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry?
9200	hours after death ural', or Itams 2:	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:		S.A. 14. Race - Amer Black, White Specify:	
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Baltimore, Maryland 21215-0036	ges 1 and 2 s of Health ar if itam 27 is or other trau		Ann Marie Kirmil 20a. Method of Disposition 1 Burial 2 Cremation 3 C	(Daughter)		Blueberr	y Hill La	ral Route Number, Cit 1., Ellico Date 20c		MD 21043
Baltim	pemit. Pag Dep riment Important: any injury once		4 □ Donation 5 □ Other (Specification of Funeral Service Licers)	y) :	22	. Name and Addre	tery 3/18 pss of Facility uneral Hou 6267 Pig	Ri ne chmond, VA	chmond, V	A
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	3		30. Name and address of person who	Lely completed cause of death	1D	D-	22609	M	Oate signed (Month, ARCH 1=	5-2004
	Sta		RUBEN REID 31. Date filed (Month, Day, Year)	32. Registrar's S	145 Fo	PNACE.	BRANCH	Rd GL	EN BURN	11E 4d 21060
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			For State Registrar		Maryland / De		of H	ealth and	Mental Hyg	•	
	, 4 E.,	. 3	1. Decedent's Name (First, Middle	Last)				P	2. Date of Death	n	3. Time of Death
	Physic /Medi		Albert Mo	ritt					March 1	Day Year 2 2004	5:30 P. M
	Examir	ner	4a. Facility Name (If not institution,	give street and numbe	or)	4b. City, To	own, or	Location of Dea	th	4c. County of De	
			Holy Cross Hosp					Spring		Montgome	
e e	Funeral Director		5. Social Security Number 081–18–8825	6. Sex 7. A	Age (In yrs. last birthd 77 Yrs	Months	Days	If Under 24 Hrs Hours Min	8. Date of Birth (Month, Day,	9. B 2,1926 Nev	rthplace (State or Foreign Country)
	\$ 11112		Usual Residence of Decedent	Λ			-		March Z	2,1926 Net	Viork
	yland		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	r 18e-f show	ctor	Maryland Montgo	omery	Silver	Spring					Y□Yes 2□No
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336	hours after tural: or Ita	by F	3 Widowed 4 Divorced		Unknown	1 ☐ Yes 🏋	□ No	Specity:		Specify: V	White
15-0036	2 hours	Completed	15. Decedent	Education	16a De	cedent's Usual	Occupa	tion	1	6b. Kind of Busines:	s/Industry
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ary	and h		19a. Informant's Name/Relationsh								Zip Code)2.0906
+ ≥	and ealth m 27		Shirley F. Mori	tt - Wife			-	- management	re, # 204,	Silver S	Spring, Md
200	ges 1 Tof H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from Stat	20b. Place of Di cemetery, o					Oc. Location - City o	Town, State
₩	dient: Pa		`4 □Donation 5 □ Other (Sp	ecify)	Judean			ns 3/15/	2004	lney, Mar	yland
ABal	permit. Pages 1 and 2 : Department of Health ar Importent: If item 27 is eny injury or other treu once:		21. Signature of Funeral Service L	censee		22. Name and . Danzans	kv-	Goldberg	Memorial	Chapels,	Inc.
	*		23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that cause	mu	1170 Ro	CLEST	illa Dil	Doolessi	110 Mars	land 20852 Approximate
	Dhusisian		shock, or heart failure. List of immediate Cause (Final						or respiratory arres	51,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		AND CHRON is a consequence of):	IC RENAL	. FA	ILURE			YEARS
1 Sept.	Examiner				ES MELLIT	JS					YEARS
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		s a consequence of):						Thirt
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	0	CHRONIC (DBSTRUCT	IVE	LUNG D	ISEASE		YEARS
760,	ate be executed hysicien and he burial-transit	cal E)	resolving in deathy East	Due to (or a	s a consequence of):						
687	physis the			d							
Box (death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy					23d. Date of de	linar
	death e atte d for	clai	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant:		3 □Ectopic preg 5 □ Other <i>(spec</i>				Month Month	Day Year
P.O.	t the o	hys	9 Unknown	9□ Unknown							
	ss tha	by P	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cau	se giver	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	requires that the death certifica been signed by the attending ph should be detached for use as it		CHRONIC ARTERIA	. FIBRILLAT	ION				1 🗆 Yes	2 □ No 3 □ XP	robably 4 ∏Unknown
ec	e 2 sh	Completed	HYPERTENSION						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u></u>	t: The		ANEMIA						performe 1 ☐ Yes 2	od? death? ☑No 1 ☐ Yes	2 □ No
Zi:	Physicien: this certific	Be	25. Was case referred to medical examiner?	Hospital:			Other		th (Check only one)		
o	Phys r this ral di	5 :	1 ☐ Yes 2X No 27. Manner of Death	I L <u>A</u> inpat	ient 2 ER/Outpat iury 28b. Time		. Injury	4 Nursing F	ome 5 Residen 28d. Describe how	ce 6 Other (Spe	city)
on	Attending r death. sctor: After	tlor	1 X Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of In (Month, D	ay Year) Injur	M	Work?	es 2 □ No	200. 2000/100 1104	injury occurred	
<u> </u>	Atter	ifice	3 Suicide 6 Could no	ad 288. Place of it	njury - At home, farm, atc. (Specify)	street, factory, o	ffice		28f. Location (Stre	et and Number or Ri	ural Route Number,
Ö	itel or rs after rel Dir led in	Certification;							City or Town,	•	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2:	Medical	29a. Certifier (Check only one) (Check only one)	Physician: To the bes caminer: On the basis and manners	or examination and/or	ath occurred at t investigation, in	the time my opi	n, date and place nion, death occu	, and due to the cau rred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	To the Ywithin 2 To the Complet	Me	29b. Signature and title of certifier) //		29c. L	icense	number	290	I. Date signed (Mont	f. Day, Year)
	(,		of com	5 8041			الم	7-200		3/13/	54
	4		30. Name and address of person w	no complete cause of	death (Item 23a) (Fyp	e, Print)	aç.	Aul	Silver	Frees A	ref
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	trar's Signature			/	5 -0 -(0//	
	Registr	ar	MAR 15 2	UU4 / C	in the	apac	2				

			For	State of Man			Health and M	•	-	0000
		ian	1 - For State Registrar			rtificate of		Reg.	2011	4 09964
	Physic		Decedent's Name (First, Middle, Last,					2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	4e. Fecility Name (If not institution, give	den		4h City Town o	or Location of Death	March:	4c. County of Dea	
	Exami	ner	University of A			Bal	Himore.	MD	4c. County of Dea	ın
	Funeral		5. Social Security Number () 6. Se:	x 7. Age (/	In yrs. last birthday)	Il Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	9. Bin	thplace (State or Foreign
	Director		003-32-0637	M 2□F	59 Yrs.	Wortins Days	Thous Will.	Dec 16	1944 New	Hampshire
	land		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary 1-f eh	ō	MD Cecil		Earlev	ille				1 ☐ Yes 2 🛣 No
	or 28g	lirec	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
	ath wi	Funeral Director	7 Summit Rd.			2191			.S.A.	
	ler då Iteme rier n	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?		Was Decedent of H If Yes, specify Cub	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Ame Black, Whit	
920	urs af	b	3 Widowed 4 Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:	-1969	1 ☐ Yes 2 🙀 No	Specity:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ane. then "natural", or iteme 23e or 28e-f show to Medical Exertine mind be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	pation during most of working	16t	. Kind of Business/	Industry
121	nen hen	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	_		
N	filed v Hygie Ither t	ပိ	17. Father's Name (First, Middle, Last)		143	nager	18. Mother's Name		estauran den Sumame)	t-Bar
lan	Mental Mental arked o	To Be	John Edward Ma	rden				th Ann		
Maryland	2 should and Men ie marke aumatic	ļ-,	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street	and Number or Rural			Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after daath with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exacting mark to notified at Angle.		Eric Marden	(son)		Mitton			City,	MD. 21915
Baltimore,	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R	lemoval from State	20b. Place of Dispo cemetery, crei	_			. Location - City or	
E m	rtmen rtmnt: rtant:	1	' 4 □ Donation 5 □ Other (Specify) 21. Sign to the of Huner I Served I sense	1	Kent Cr				myrna,	
Bal	permit. Page Department (important: if any injury or once.	1	21. Signature of Huneral Server Electric		00510 Î	alena F 18 West	suneral H Cross S	ome of t. Gale	Stephen	L Schaech 21635
	•		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each line.						Approximate Interval Between Onset and Death
	Physician // Medical		Immediate Cause (Final disease or condition resulting in death)			ronary	Artery	disease		Onset and Death
	Examiner		1	Due to (or as a co	onsequence of):	0	0			
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760,	be exician sician s	cai Ex	resulting in death) cast	Due to (or as a co	onsequence of);					
687	icate physics the			1						
Box (The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d. Date of deli	very
_	that the death cer ed by the attendin detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	hat the d by t setach	Phy	9 ☐ Unknown Part II. Other significant conditions cor		ot roouting in the		an in Dani	OZa Didashara		
ds,	signed l	d by	Partin, Julian significant conditions con	indusing to coatif but if	or resulting at the di	idenying cause giv	en in Fanti.	1 Tes	_	the cause of death?
Records,	w require been sig should t	ete						24a. Was an		topsy findings available
Re	The law ate has page 2.9	Completed						autopsy performed	prior to c	ompletion of cause of
Vital	ilcian: Th certificate rector, pag	BeC	25. Was case referred to medical				26. Place of Death		No 1 Li Yes	2□ No
of V	d is X	10	examiner? 1 ☐ Yes 2 X No	lospital: 1 X Inpatient	2 ER/Outpatien	t 3 DOA Oth		V	6 ☐Other (Spec	ify)
n o	ding Ph th. After thi funeral	io ii	27. Manner of Death 1 ★Natural 5 Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	28c. Injun Work	k?	ld. Describe how in	njury occurred	
Division	death. ctor: A y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At home larm, str		Yes 2 □ No	Il Location (Street	and Number or Ru	ral Pouto Number
Ö	al or after	Certification;	4 Homicide determined	building, etc. (5	Specify)	out, lautory, onlow		City or Town, St.	ate)	ar noute warnoer,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filted in by the fune.	Medical C	29a. Certifier (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the timestigation, in my of	ne, date and place, ar pinion, death occurred	d due to the cause I at the time, date a	o(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier		<u> </u>	29c. License	a number	29d. [Date signed (Month	, Day, Year)
	71.		> XHUNT	T. M.D.		P	16471		3/25/00	4
	4		30. Name and address of person w o co		h (Item 23a) (Type,		·			
	,		Debra Hickory S 31. Date filed (Month, Day, Year)	22 Penietraris	sionature	s. Baut	MIDIE / MID	21001		
	Sta Registi		M	AR 3 1 2004	J. B. Beller	A A	imore, MD			

		1 - For State Registrar			nd / Depa		t of H	ealth ar	nd Mental		e 200)4 0996	
Physici /Medic Examir	al	Decedent's Name (First, Middle, Last Lee Nearhoof S 4a. Facility Name (If not institution, give	r	ber)		4b. City,	Town, or	Location of [2. Date of Month	26, 2	ay Yea	9:40 P M	_
Funeral Director	er	Montgomery Genera 5. Social Security Number 6. Se 196-14-8451 10	l Hospi	tal	last birthday) Yrs.	O If Under Months	lney 1 Year Days	If Under 24 Hours	Min. (Mont	of Birth h, Day, Yea 30, 1		nery Birthplace (State or Foreign Country) Insylvania	ח
the Maryland 28a-f ehow	Director	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome 1 10e. Street and Number	sy		ty, Town or Lo		Code			10g. C	citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☐ No Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show amy injury or other traumatic event, the Medical Exam per must be notified at once.	by Funeral	13538 Vanda1ia Dr: 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	LVE 12. Was Deced Apped Ford 1 Pyes 2 If Yes, Give Year or Date	es? ! □ No	Ţ	Was Dece if Yes, spe 1 Yes	2 No	Specify:	n? (Specify Yes Puerto Rican, etc	or No-	Black, W Specify:	nite	_
ed within 72 lygiene.	Completed	15. Decedent's Edi (Specify only highest grace Elementary/Secondary (0-12)	College (1-	4or 5+)		kind of wo	rk done di se retired) river	uring most o		M	etro	ss/industry	
ary large should be fill and Mental Hy marked oth numatic event	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, 1						el Kooke	en				
ages 1 and 2 and of the fittern 27 is		Timothy Nearhoof/Son 13538 Vandalia Dr. Rockvil 20a. Method of Disposition 1 Burial 2 A Cremation 3 Removal from State							Date	20c. Location - City or Town, State			
permit. Pages Department of important: If it any injury gr o		21. Signature of Funeral Service Licens	le		11	2. Name ar 1800 1	d Address	s of Facility Lampsn		inaldi Silv	F.H.	mD ing, MD 2090	4
Physician /Medical		23a. Pan). Enter the disease. Of amp strick, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Acute	ch line.	ratory			, such as ca	rdiac or respirati	ory arrest,		Approximate Interval Between Onset and Death	_
ate be executed hysician and he burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pneumonia Due to (or as a consequence of): Sepsis Due to (or as a consequence of):											
sicien: The law requires that the death certificate be executed certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ □ ∪ O O O O O O O O O O O O O O O O O O		th 2 ☐ Feta nt at time of c	al death 3	Ectopic p				All Income and the second	23d. Date of o	delivery Day Year	555
w requires that been signed b	by								Did tobacco	coluse contribute to the cause of dealh?			
ician: The law retificate has be	e Completed	Atrial Fibrillation 1 Yes 2 No 1 Yes 2 No								o completion of cause of	_		
To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	26. Place of Death (Check only on 1 3 DOA Other: 4 Nursing Home 5 Reside 28c. Injury at Work? M 1 Yes 2 No				Residence						
vital or Atteurs after degrate in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route N City or Town, State)											
the Hosp ithin 24 hoi the Fune	Medical	29a. Certifier 1 ☐ Certifying Phyone) 29b. Signalure and title dicertifier		sis of examina		vestigation		inion, death		ime, date a	nd place, and d		
15		30. Name and address of person who c	ompleted cause	of death (Ite	m 23a) (Type,		04	539		fe	b	27,04	
Sta Regist		Dr. Chukwuemeka N 31. Date filed (Month, Day, Year) MAR 0 8 2004	32.#Re	8101 P gistrar's Sign		1	p Dr		y, MD 20	0832			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year JANE NORFLEET 7:25 PM 29 02 2004 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Mantgarery Fox Chase Rehab & Nursing Center Silver Spring 7. Age (In yrs. last birthday) 80 yrs If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) March 15,1923 5. Social Security Number Birthplace (State or Foreign Country) Days Months Hours 1 ☐ M 2 □ F 227-26-6219 Nash Co., NC. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 209 Rittenhouse St. N.E. 20011 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ Xio If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Black Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry private Elementary/Secondary (0-12) College (1-4or 5+) Casimo Clerk 12th 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) George Winstead Lessie Jane Taylor 19a. Informant's Name/Relationship (Type, Print) Wilma Norfleet, Daughter 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 209 Rittenhouse St. N.E. Washington, DC 20c. Locetion - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date Winstead Family Cen 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elm City 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bianchi F.S. 814 Upshur St. NW, Washington, DC. 20011 e, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each line. Approximate Interval Between Onset and Death Cardiorespiratory Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

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D.C.

Funeral

Director

show

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any finury or other traumatic event, the Medical Experies

Saltimore, Maryland 21215-0020

death with the Maryland

Examine Physician/Medicai þ Completed Be ů Certification:

certificate be executed attending physician end for use as the bunel-trans signed by the a id be detached f peen s hes this ual or Anc.
Jurs after death.

val Director: After the by the funer. funeral To the Hospital within 24 hours a To the Funeral Completely filled

Division of Vital Records, P.O. Box 68760

Medicai 10

Part II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

2 ☐ Accident

4 ☐ Homicide

(Check only

29b. Signature and title of certifier

3 ☐ Suicide

29a Certifier

5 Pending investigation

6 Could not be determined

PHYSICIAN

28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D0061096

28c. Injury et Work?

1 Tes

2 ∏No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 🗆 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Plece of Death (Check only one)

2 IZ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOLLAPALLI USHA, 86092nd Ave, Silver spring MD 20910

1 Certificing Physician: To the best of my knowledge, death occurred at the time data and plane, and due to the causalst and manyer as stated

State Registrar

31. Date filed (Month, Day, Year) B2. Registrar's Signature MAR 0 9 2004

			1 = For Unpend Item#23a, Registrar	State of Maryla PartII,27,PerME,	nd / Depa G83 04/7	artment of I	Health and <i>Death</i>	Mental Hygi	iene 19. No 2004	09967	
		.	1. Decedent's Name (First, Middle, Las		2. Date of Death Month Day Year 3. Time of Death						
	Physicia /Medic		JOHN				March 8	ch 8 2004 415 a M			
	Examin		4a. Facility Name (If not institution, give Prince Georges H				th	4c. County of Dea			
	Funeral Director		5. Social Security Number 6. Se 218–98–9124	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days			9. 8ii 3 1959 Ni	thplace (State or Foreign ountry) geria	
)	pu 🖈		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
	Marylan -f show	tor	MD Prince G		Landove					1 ☐ Yes 2 ☐ No	
	or 28a	Funeral Director	10e. Street and Number 1504 Brightseat R	oad # 102		10f. Zip Code	785	10	Og. Citizen of What C	ountry?	
	death v	eral	1304 BIIghtseat I	12. Was Decedent Ever in	U.S. 13.			Specify Yes or No- rto Rican, etc.)	14. Race - Am		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "netural", or Items 23e or 28e-f show if item 27 is marked other than "netural", or Items 23e or 28e-f show or other traumatic event, Ite Medical Examinar must be notified at	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 XNo		rto Hican, etc.)	Specify: B	te, etc. 1ack	
Maryland 21215-0036	thin 72 ho e. en "netur Medical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of we		16b. Kind of Business		
21	filed wi Hygien other th			4	Self		10 Matheda Ne	ame (First, Middle, N	Private		
yland	2 should be filed within and Mental Hygiene. is marked other than raumatic event, the Me	To Be	17. Father's Name (First, Middle, Last) Jason Nwokoro				Abig	ial Azi			
	nd 2 sho lith and 27 is m r traum	in 8	19a. Informant's Name/Relationship (7 Placida Nwokoro/V						City or Town, State, Maryland		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra ance.		20a. Method of Disposition 1 ₺ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	osition (Name of matory or other pla			20c. Location - City of		
Ħ	permit. Pag Department Important: I any injury o		*4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Ucen		amily E				kaboo Atti ins Funera		
Ba	permit. Departr Importa any inju		X. D. Mar	chall					, Maryland		
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only Immediate Cause (Final disease or condition	olications that caused the de one cause on each line. Hypertensive H			ing, such as cardia	ac or respiratory arre	est,	Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):						
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8760,	sate be executed oby sician and the burial-transit	al Exar	that initiated events resulting in death) Last	Due to (or as a consequence of):							
9	tificate ig phy: as the	ledic		· · · · · · · · · · · · · · · · · · ·							
.O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnand □ Other (specify) _	су		23d. Date of de Month	3d. Date of delivery Month Day Year	
Q	as that I gned by se deta		Part II. Other significant conditions of		esulting in the u	underlying cause g	ven in Part I.			o the cause of death?	
ord	w requires to been signed should be	eted	Probable Hemoglobinop	athy						robably 4 Unknown	
Il Records,	The la ate has page 2	Completed by						24a. Was ar autops perform 102 Yes 2	n 24b. Were a prior to death?	utopsy findings available completion of cause of	
Vital	ician Sertific ector	Be	25. Was case referred to medical examiner?	Hospital:		0:	hor	eath (Check only one	(1) I I I I I I I I I I I I I I I I I I I		
of	Physician: r this certific ral director,	- To	1 X Yes 2 No 27. Manner of Death	1 □ Inpatient 2	☐ ER/Outpatie 28b. Time o	nt 3 STDOA	4 Nursing	Home 5 ☐ Reside 28d. Describe ho	nce 6 Other (Spewinjury occurred	ecify)	
ion	Attending F r death. sctor; After by the funer	atlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	Wo	ork?]Yes 2∐No				
Division	al or Attendi s after death. I Director; A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, st	farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C		ysician: To the best of my k niner: On the basis of exami and manner stated.							
	To the within To the compl	Me	29b. Signature and title of certifier		Qnn.	29c. Licer	se number	29	ed. Date signed (Mon March 9	•	
0			30 Name and address of person who	COMPLETE CALLES OF COSTS (1)	am 23a) /Tues	-10 ·			i ice Cii		
_	3/		Pateins Ara	Nica-Polls	KMI	111 1	Penn Stre	eet, Balti	imore, Mar	yland 212	
	Sta	ate	31. Date filed (Month, Day, Year) MAR 1 6 2004	32. Registrar's Sig	nature	R)					

			1 - For State Registrar	State of Maryland		artment of Hertificate of L			giene Reg. No2	004	19968	
	Physici	an	Decedent's Name (First, Middle, Last, TRACY	NADEL		-		2. Date of Dea Month MARCH	ath Day	Year	3. Time of Death	
	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	MAKCH 2	-	ounty of Death	10:25 A M	
	LXaiiiii	CI	5605 SOUTHWICK ST	REET		BETHESDA	A		MON	TGOMER	Y	
	Funeral Director		Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min. M	8. Date of Birt (Month, Da) AR. 13,	h y, Year) 1950	9. Births Cour NEW	place (State or Foreign htry) YORK	
9	pur 🗼		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits	
	Aaryla F sho	៦									1 ∑Yes 2 ☐ No	
	with the had or 28a- the notified	Director	MARYLAND MONTGOME 10e. Street and Number 5605 SOUTHWICK S'		BETHES	10f. Zip Code 2081	17		-	n of What Cour	otry? OF AMERICA	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinational the notified at ance.	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White,	etc.	
Maryland 21215-0036	n 72 hour: "natural" edical Ex	Completed by	3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occupa kind of work done do DO NOT use retired)	uring most of worki	ng	16b. Kind	of Business/In		
12	l withii iene. r than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		CORNEY			FEDER	RAL GOVI	ERNMENT	
פ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Su	ımame)		
/lar	Menta Menta arked	ToE	MELVIN NADEL				CLARE	WILDMA	N			
Jan	2 sho		19a. Informant's Name/Relationship (7)			ng Addres <i>s (Str</i> ee <i>t</i> a MERCER STI						
e,	1 and Health em 27 thar t		ALLISON HORNSBY -	20b. P	ace of Dispo	sition (Name of				tion - City or To		
nor	ages ant of triffit		1 ☑ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, cren	natory or other place EBANON CEN		07/04		N, NEW		
Baltimore,	permit. P Departme Importan any injur		21. Signature of Euneral Service Licens	1,51,	22 D <i>i</i>	Name and Address	s of Facility GOLDBERG	MEMORI <i>A</i>	L CHA	APELS.	INC.	
			23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw									
F	hysician /Medical Examiner		snock, or near tailure. List only o Immediate Cause (Final disease or condition resulting in death)	a. CARDIAC ARE							Interval Between Onset and Death	
				b. Due to (or as a consequence of): METASTATIC RENAL CELL CARCINOMA Due to (or as a consequence of):								
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
•	xecuted and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last RENAL CELL CANCER Due to (or as a consequence of):									
8760,	icate be executed physician and s the burial-transit	dical	· ·	d					<u>.</u>			
.O. Box 6	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 ☐No 9 ☐ Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			230	d. Date of delive	ery Day Year	
۳.	that the part of t	y Ph	Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?	
rds	w requires been sign should be							1 🗆 Y	′es 2.[X]t	No 3□Prob	ably 4 Dunknown	
Vital Records,	ysician: The law requis certificate has been director, page 2 shout	Completed						autop	autopsy prior to performed? peath?		psy findings available mpletion of cause of 2 No	
		Bec	25. Was case referred to medical examiner?				26. Place of Death		21		237.0	
ot O	Physic this ceral dire	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ I			r. 4 Nursing Hor				y)	
Division o	ding P. h. After t funera	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe h	ow injury o	ccurred		
	Atten	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	be and Blood of Jajuny. At home form street feature office.				28f. Location (Street and Number or Rural Route Number, City or Town, State)			I Route Number,	
٥	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by											
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 1 ☐ Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place, a inion, death occurre	and due to the o ed at the time, o	cause(s) an date and pla	id manner as st ace, and due to	ated. the cause(s)	
	To the To the comple	Me	29b. Signature and title of certifier	and mannor stated.		29c. License	number		29d. Date s	igned (Month,	Day, Year)	
	(10)		1 (Cutomo)	am wet		מכת	0110	м	ARCH	4, 2004	<u>'</u>	
	6		30. Name and address of person who co			Print)					20852	
			ANTONIO TITO FOJO			12N226 9	9000 ROCK	VILLE P	IKE,	ROCKVII	LLE, MD	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 5 200	32. Registrar's Signat	ure &	Sporks	·					

	1	For State Registrar	State of Maryland	/ Departme <i>Certifica</i>	nt of Health and te of Death		Reg. No.	
		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day Year	3. Time of Death
Physicia /Medic		Robert Ohlbaum				March		6:30 P ^M
Examin		4e. Fecility Name (If not institution, give st	reet and number)	4b. Cit	y, Town, or Location of De	ath	4c. County of Deat	n
		11200 Lockwood Dr,	#1015		Silver Spri		Montgom	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	Month	er 1 Year If Under 24 H s Days Hours M	n. (Month, Da	y, Year) Co	hplace (State or Foreign untry)
Director		056-16-8616	86	Yrs.		Sept 9	, 191/ Ne	w York
ma 23a or 28a-f show		Usuel Residence of Decedent 10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
hov	-	Tod. State						1 ☐ Yes 2X No
Sa f	Director	Maryland Montgom	ery Si	lver Spri	ng Zip Code		10g. Citizen of What Co	untry?
or 2		10e. Street and Number		101.				
nd Mental Hygiene. markad other than "natural", or Itama 23a or 28a-f ahow imatic avent, the Medical Exertimer must be notified at		11200 Lockwood Dr,	#1015	12 Wes Do	20901	(Specify Yes or No	USA 14. Rece - Ame	rican Indian.
lama arr	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	erto Rican, etc.)	Black, Whit	
2		1 Never Married 2 Married	1 ☐ Yes 2√ No If Yes, Give	1 ☐ Yes	No Specify:		Specify:	TTL: 4 + a
E A	d by	3 Widowed 4 Divorced	Year or Dates:	16a. Decedent's U	eual Occupation		16b. Kind of Business.	White Industry
Tat Gles	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give kind of life. DO NO	work done during most of t	working		,
Den .	E G	Elementary/Secondary (0-12)	College (1-4or 5+)		al Engineer		Governmen	t
it, th		17. Father's Name (First, Middle, Last)	5+	Mechanic		Name (First, Middle	, Maiden Sumame)	
harked other hatic avent, II	Be	17. Father's Name (First, Micole, Last)						
arka atic	2	Meyer Ohlbaum		405 44-15 4-14-	Fannie ess (Street and Number or	Adelson	er City or Town State	Zin Code)
		19a. Informant's Name/Relationship (Typ						
Department of Health a Important: If Item 27 is any injury or other trat once.		Mollie Ohlbaum/Wif	e and B	11200 Locace of Disposition (kwood Dr. #1	Olf, Sil	ver Spring	MD 20901 Town State
r ott		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	moval from State	metery, crematory	or other place)			
int: h		`4 □ Donation 5 □ Other (Specify)	Kir	ng David N	iem Grdns Ma	ar 12, 20	04 FallsCh	urch, VA
y inju		21. Signature of Funeral Service License	* // 2		and Address of FacilityH			
3 = 8		lan T- 1	WE		New Hampsh			ng, MD 2090
**		23a. Part . Enter the disease, or complication shock or heart failure. List only on	cations that caused the death	. Do not enter the r	node of dying, such as care	diac or respiratory a	rrest,	Approximate Interval Between
1		Immediate Cause (Final						Onset and Death Weeks
sician edical		disease or condition resulting in death)	Due to (or as a consequ	re to Thr	ive			WEEKS
miner				ate Cancer	^			2 yrs
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ					
nsit	듶	cause. Enter Underlying Cause (Disease or injury						
ohysician and the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):				
ician buris								
phys the	dical							
attending p	/Me	IF FEMALE: 2	3c. If yes, outcome of pregna	ncy			23d. Date of de	livery
or us	an	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3⊟Ectop	c pregnancy (specify)		Month	Day Year
the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	5	(
ed by the detached	Phy	Part II. Other significant conditions con	tributing to death but not resi	ulting in the undertyi	ng cause given in Part I.	23e. Did	tobacco use contribute	o the cause of death?
De pe	þ	Coronary Artery		,y		1 🗆	Yes 2XÎNo 3∏F	robably 4 Unknow
pinous should	Completed	Colonaly Altery	7_0000			0.5		utament finalisas anadala
2 5	pie					_ 24a. Wa auto	s an 24b. Were a prior to death?	utopsy findings available completion of cause of
ate ha	lo.					1 ☐ Yes		s 2 No
of.	Be	25. Was case referred to medical examiner?				Death Check on	one	
	10	1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursi		sidence 6 Other (Sp	ecity)
er this ieral di		27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	how injury occurred	
F. Aft	atio	1 Natural 5 Pending 2 Accident investigation	,	М	1 ☐ Yes 2 ☐ No			
octor; A	5	3 Suicide 6 Could not be determined	28e. Place of Injury - At his building, etc. (Specif	ome, farm, street, fa	ctory, office	28f. Location City or To	(Street and Number or Fown, State)	Rural Route Number,
To the Funeral Director; After completely filled in by the funer	Certification:	4 Diomone	building, atc. (opacii	"				
To the Funeral Dir completely filled in		29a. Certifier 1 X Certifying Phy	sicien: To the best of my kno	wiedge, death occu	rred at the time, date and p	place, and due to the	e cause(s) and manner	is stated.
within 24 nours To the Funeral completely filled	Medical	(Check only 2 Medical Exami	ner: On the basis of examina and manner stated.	ition and/or investiga	ition, in my opinion, death	occurred at the time	e, date and place, and di	e to the cause(s)
o the	₹	29b. Signature and title of certifier	. ~		29c. License number		29d. Date signed (Mo)	nth, Day, Year)
s ⊢ ŏ		1 Kg	M		D25314		March	11, 2004
10		30. Name and address of person who c	modeled cause of death (Iter	n 23a) (Type Print)				
1					d, #209, Sil	ver Sprin	o. MD 20904	
		Robert J. Ginsber	g, MD 2415 M 32. Registrar's Signa	aturo /	/	AET PATTI	15, III 2070-	
	tate	31. Date filed (Month, Day, Year) MAR 1 5 200		D 1	south			

State of Maryland / Department of Health and Mental Hygiene 00 1 09970 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 March 11, Olmstead 4:24 PMM Ε. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Nov. 26, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 6 Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□ M 2X□ F Days Hours 85 1918 Nov. Director 126-03-9598 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 321 University Blvd., Apt. #131 20901 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Proof Reader Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harvey Walters Marie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 10120 Tenbrook Dr., Silver Spring, MD 20901 Janette L. McCoy (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Elmlawn Cemetery 3/15/04 Tonawanda, NY * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hamp Funeral Home, Inc. 37 Adam St., Tonawanda, NY 14150 Olman lennis 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acute renal failure /Medical Due to (or as a consequence of). **Examiner** Sepsis

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Clostridium dificile colitis and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to comptetion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certitier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Juna Curnming, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0058919 03/11/2004 3 Gina Cummings, MD
31. Date filed (Month, Day, War) 8807 Colesville Road, Fifth Floor, Silver Spring, MD 20910 32. Registrar's Signature State MAR 1 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** Robert H. Offer March 5 2004 1510 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Arunde1 Anne Anne Arundel Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months t**∑**M 2□F 66 Feb. 6 1938 Maryland Director 219-38-5569 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State item 27 is marked other then "naturel", or items 23s or 28s-f shov other treumstic event, the Medical Example in out to motified at 1X Yes 2 No Director Maryland Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 502 Royal Street 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after I MYes 2 □ No
If Yes, Give
Year or Dates: 1961-63 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12th 0 Grounds Foreman es 1 and 2 should be filed w of Health and Mental Hygie if item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Solomon E. Offer Beverly E. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 502 Royal Street Appropriate Md.

20b. Place of Disposition (Name of cametery, crematory or other place)

Date 20c. Location - City Susan A. Offer (Wife) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Importent: If ites
any injury or oth 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran * 4 ☐ Donation 5 ☐ Other (Specify) 3/10/04 Crownsville, Md. Cemetery. Name and Address of Facility 21. Signature of Funeral Service Licensee 21. Signature of Funeral Service Liberisee

Wm. Reese & Sons Mortuary, P.A.

821 West Street Annapolis, Maryland 21401

Approximate Interval Between Onset and Death

Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death

Onset and Death Immediate Cause (Final disease or condition resulting in death) Septic Shock Physician /Medical Due to (or as a consequence of) Bowel Examiner Obstruc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner and Il-transit the death certificate be executed Due to (or as a consequence of): physician ar s the burial-t Box 68760 Physician/Medical use as signed by the attending I IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de: 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown ď 23e. Did tobacco use contribute to the cause of death? Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ves 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 Broncho de 1 🗌 Yes 2 **I**Mo Division of Vital To the Hospitel or Attending Physiclen: Be 25. Was case referred to examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 patient 2 ER/Outpatient 3 DOA Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manue of Death 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 4 - Homicide 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 9005829 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Young MO Medical Anne 1000ARD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 09 Registrar

Martin J. O'Brien Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-02077 MAN Unpend Item #23a, State of Maryland Department of Poath 1 - For Ustate Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** O'Brien Martin John March 24 /Medical 2004 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3508 Fullerton Street Beltsville Prince George's

9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Nov. 15, 1968 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1□XM 2□ F Months Hours 35 Maryland 219-90-3491 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show r than "natural", or itams 23a or 28a-1 shov the Medical Examiner must be notified at Director Beltsville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20705 USA 3508 Fullerton Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Govt. Computer Analyst marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be the head Mental I Patrick Joseph O'Brien Peggy Anne Wright end N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health er important: If Item 27 is r. Peggy Anne Schneibolk/mother 9000 Burma Rd. #102 Palm Beach Gardens 20c. Location - City or Town, State 33403 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-29-2004 Brentwood, MD. Lincoln Cem. * 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 20715 23a. Pent1. Enter the disease, or complications that couled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one passe on a prise of the death. Disease complicated by Mixed Drug Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) (methadone, oxycodone&diazepam) Intoxication **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown

Division of Vital Records, P.O. Box 68760 been signed by the should be detached The law requires that ۵ Completed certificate has a rector, page 2 s has or Attending Physician: after death.

Director: After this certific Be

Day

23e. Did tobacco use contribute to the cause of death?

Year

2310 P

1 □ (Yes 2 □ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed?

1 ☐ Yes 2 ☐ No

3 Probably 4 Unknown

1 Yes 2 □ No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

12 Yes 2 \sum No

25. Was case referred to medical 1X Yes 2 No 27. Manner of Death

29b. Signature and title of certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending

investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 3/24/04 28b. Time of FO:00

28c. Injury at Work? РМ

1 ☐ Yes 2 No

Other: 4 Nursing Home 5 Residence 6 QOther (Specify) At scene 28d. Describe how injury occurred Unknown

> 28f. Location (Street and Number of Rural Route Number, City or Town, State) 3508 Fullerton St. Beltsville, Md

Found at home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

O.C.M.E.

29c. License number

March 25, 2004

30-Name and address of person who completed cause of death (Item 23a) (Type, Print)

CMD11 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar

completely

within 2.

2

Certification:

Medical

fo the Hospital 24 hours a

State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:25 P M SARRA MARKOVNA PUKSHANSKAYA MARCH 8 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner ROCKVILLE MONTGOMERY 512 MONET DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Mache Dave Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 🂢 F 25, 87 FEB. 1917 RUSSIA 215-59-7050 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Madical Examinating the multipled at agree. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Directo MARYLAND | MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 512 MONET DRIVE 20850 RUSSIA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE ģ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) TELECOMMUNICATIONS 4 HUMAN RESOURCE MANAGER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KRIMAN REBECCA SHURAK ٩ MARK 19a. Informant's Name/Relationship (Type, Print) GRANDSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDER GRIGORYEV/IN-LAW 512 MONET DRIVE, ROCKVILLE, MARYLAND 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESSED SHEL EMMES 03/10/2004 WASHINGTON, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a OSTEOPOROSIS Physician 20 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20 YEARS STEROID MEDICATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DEMENTIA Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 2 \(\text{No} \) this certificate 1 ☐ Yes Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☒ No Certification; To 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death After t or Attending 1 🛮 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours after death.

neral Director. A

filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 319104 1)0009317 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2333 S. NASH ST. ARLINGTON, VA. 22202 ROBERT F. BYRNE, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State racker MAR 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 09971

		Certificate of Dea	ath Reg. No.								
	Division	Decedent's Name (First, Middle, Last)	2. Dete of Death Month Dey Year 3. Time of Death								
The No.	Physician /Medica	naria n. raez	March 16, 2004 6:30 PM								
	Examiner	, and the same of	ty, Town, or Locetion of Deeth 4c. County of Deeth								
	6.		Koma Park Montgomery Juder 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign								
	Funeral Director	578-64-5296 Usual Residence of Decedent	State of Birth (Month, Day, Year) September 27, 1932 September 27,								
	/land	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits								
	Man and and and and and and and and and a	Maryland Montgomery Potomac	1 ☐ Yes 2 ☑ No								
	in the	10e. Street end Number 10f. Zip Code	10g. Citizen of What Country?								
	ath w	11701 Winterset Terrace 20854									
020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Manyland Department of Health end Mantal Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show early highly or other traumatic event, the Medical Examination must be notified at once.		ic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: Ecuadorian White								
Š	2 hou	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry								
212	ed within 72 hours e ygiene. Ner than "naturel", o nt, the Medical Exar Commissed by	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	i most or working								
2	ed will ygien it, the	12 Homemaker	Own Home								
Baltimore, Maryland 21215-0020	Mantal H Marked oth artic even	17. Fether's Neme (First, Middle, Last)	Mother's Name (First, Middle, Maiden Surname) .ucrecia Reynel								
ary	shoul nd Mi		Number or Rurel Route Number, City or Town, State, Zip Code)								
Σ	and 2 alth e 27 is	Fernando Jimenez, Sr./Brother 16808 Camberford	Street, Derwood, Maryland 20855								
ore	of He	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State								
Ĕ	Page ment	4 □ Donation 5 □ Other (Specify) Gate of Heaven Ceme	tery 2004 Silver Spring, Maryland								
Bail	Departing Depart	21. Signature of Funeral Service Licensee 22. Name and Address of Robert A. Pum 7557 Wisconsin	Facility Iphrey Funeral Home/ Chase, Inc. I Ave., Bethesda, MD 20814-3501								
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, of heart failure. List only one cause on each line.									
45.	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Renal Failure Due to (or as a consequence of):	Onset and Death								
Box 68760,	Attending Physicien: The law requires thet the death certificate be executed a releath. ector: After this certificate has been signed by the attending physician and by the funeral director, pega 2 should be datached for use es the bunal-transit lifeation: To Be Completed by Physician/Medical Examines.										
Р. О. В	v requires thet tha death ce been signed by the attendi should be datached for use	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in	Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
Division of Vital Records,	The law requires the cate has been signed; pega 2 should be completed by		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?								
<u> </u>	The ate h		1 V35 2 No 1 Yes 20 No								
<u> </u>	clen:	25. Was case referred to medical examiner?	Place of Death (Check only one)								
0	Physic this c ral dire	1 Tes 2/04/00 1 Testinpatient 2 EH/Outpatient 3 DOA 4	□ Nursing Home 5 □ Residence 6 □ Other (Specify) 28d. Describe how injury occurred								
5	dlng h. After fune	27. Magner of Death 1									
JIVISI	P#F	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Physicien: The I within 24 hours effer death. To the Funeral Director: Attenthis certificate has sompletely filled in by the funeral director, page. Medical Certification: To Be Com										
D	Within Within To the Somple		29d. Date signed (Month, Day, Yeer) 3/17/04								
	\'	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)	nston Houstst Hosp								
4	State Registrar	31. Date filed (Month, Day, Year) MAR 1 9 2004 32. Registrer's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 09975 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2<u>004</u> Month **Physician** March 11, 7:38 A M Bobbye June Parker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Williamsport

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Homewood at Williamsport 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 □ M 2 🕅 F 414-40-0353 Mar 11, 1929 Tennessee Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or items 23e or 28s-f ahow the Musical Examinat has be rediffed at 1 Yes 2 No Be Completed by Funeral Director Williamsport Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21795 16505 Virginia Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2V No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2♥☐ No Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications 12 Manager other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Parker John Underwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai Pages 1 and 2 4627 Brightwood Rd, Olney, MD 20832 Robert W. Parker/Son Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State Silver Spring, MD Mar 15, 2004 * 4 □Donation 5 □ Other (Specify) Gate of Heaven Cem 21. Signature of Funeral Service Licensag 22. Name and Address of FacilityHines-Rinaldi Funeral Home Nance 11800 New Hampshire Ave, Silver Spring, MD 20904 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the diserve, or complications that caused the shock, or hear failing. List only one cause on each line. Immediate Cause (Final disease or condition Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death
9☐Unknown 5 Other (specify) 1 □ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormeg./ 2⊠ No 1 Yes 2 No San diss/10 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: Will Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending **P**⊠Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a Hospitel **Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Typen Print) w. E. Kutzers, MD NS/Le 47 31. Date filed (Month, Day, Year) MAR 17 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:35P M March 18 , 2004 PATTERSON **Physician** AKHTAR **ZOHRA** /Medical 4c. County of Death 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3407 Laurel Avenue Cheverly Prince George's tf Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5 Social Security Number **Funeral** Months Days Hours 10 M 20 F 62 Apr. 1, 1941 Virginia 579-54-8986 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or itams 23a or 28a-f ahow Tre Medical Examiner must be notified at 1 √Yes 2 □ No Prince George's Cheverly Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 United States 3407 Laurel Avenue permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a any printry or other traumatic event, if a Medical Exp. if ar must once. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Arab If Yes, Give Year or Dates: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) Accountant United Cerebral Palsy 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Washington Wilma Francis Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Idris Samawi Hamid -son 9431 Rist Canyon Rd. Bellvue, CO 80512 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Maryland National Mem. Park 3/17/2004 Laurel, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months? ò 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part tl. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ pp 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 2 No certificate 2 No 1 Tyes Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident hours after death 6 Could not be determined 3 Suicide Place of Intury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the within 2 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year) D-0018862 100 /2 16 30. Name and address of person who completed cause of death (Item 23a) (Type. Print)
Chuntung Changchien M.D. 8824 Cunningham Dr., Suite D, Berwyn Heights, Md. 20740 31. Date filed (Month, Day, Year)
MAR 18 2004 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 8:45 P Pham March 14 2004 Chung /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Layhill Center / Genesis Healthcare Silver Spring Montgomery If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Days 1 ☐ M 2 🗓 F Director Feb. 3, 1916 217-96-4192 88 Viet Nam Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Montgomery Silver Spring Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 20904 531 Randolph Road #240-A Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours aftar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Asian ρ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home i. Pagas 1 and 2 should be filed vitnent of Health and Mental Hygientant: If item 27 is marked other tigury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Pham / son 711 Pebble Beach Dr., Silver Spring, MD Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Department of Himportant: If its any injury or of once. cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 3-18-2004 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Departr 21. Signature of Euneral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 or complications the cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause in each line. Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebral Infarct /Medical Due to (or as a consequence of): Examiner General Debility Sequentially list conditions, Due to (or se a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death cartificate be executed Depression physicien and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Dehydration Physiclan/Medical as the the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death USB 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Dav Year ō 4 □ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ģ det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> 3 Probably 4 □Unknown 1 🗌 Yes 2 X No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performe certificate 1 Tyes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 2 ER/Outpatient 3□ DOA this. 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a TO Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 dum D00058965 March 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11119 Rockville Pike, Rockville, MD Saima Khawaja, M.D. 31. Date filed (Month, Day, Year) MAR 1 7 32. Registrar's Signature State 2004 Registrar

			T = For State Registrar		f Maryland / [Depa <i>Cer</i>	rtment of H	lealth and M Death	lental Hy	gien	e.200L	09978
	Physici /Medic	cal	Decedent's Name (First, Midd LEONARD	KENY		PORT	UGUESE	1000	2. Date of De Month MARCH	9,	ay Year 2004	3. Time of Death 7:30 P M
	Examir Funeral	ier	4a. Facility Name (If not institution 2931 BIRCHTREE 5. Social Security Number	LANE 6. Sex	7. Age (In yrs. last bin	thday)	SILV If Under 1 Year	ER SPRING	8. Date of Bi	rth	MONTG	
	Director		153-18-2896 Usual Residence of Decedent 10a. State 10b. County	1 M 2 □ F	82	Yrs.	Months Days	Hours Min.	(Month, Da			JERSEY 10d. Inside City Limits
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92	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or items 23a or 28a-f show event, it a Medical Examinat must be notified at	y Funeral Director	2931 BIRCHTRE 11. Marital Status 1 Never Married 2 Mar	12. Was Dece Armed For ried 1 7 Yes	2 □ No			906 ispanic Origin? (Spen, Mexican, Puerto Specify:			14. Race - Ame Black, Whit	e, etc.
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Baltimore,	Dermit. Page Department o Important: If any injury or ance.		1 \(\sqrt{8}\text{urial} \) 2 \(\sqrt{Cremation} \) 4 \(\sqrt{Donation} \) 5 \(\sqrt{Other} \) (3 21. Signature of Funeral Service	Specify)	olale	ND '	VETERENS 1	CEMETER	Y			MARYLAND
Total State of the last	Pnysician /Medical Examiner		23a. Part. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a	aused the death. Do nach line. LODYSPLAST. or as a consequence of the sequen	A of):					E,MD 208	Approximate Interval Between Onset and Death 7 ½ YEARS
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.O. Box 6	The law requires that the death certific tate has been signed by the attending page 2 should be detached for use as:	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live bi	come of pregnancy orth 2 Tetal death ant at time of death wn		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
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Division of Vi	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification; To Bo	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi 3 Suicide 6 Could	Hospital: 1 Ir Ir 28a. Date o (Month	patient 2 ER/Out f Injury n, Day Year) 28b. T. In of Injury - At home, far	ime of	28c. Injury Work M 1 🗆 Y	′es 2 □ No	ne 5 A Resid	dence now inju	ry occurred	ral Route Number,
Δ	To the Hospital or A within 24 hours after To the Funeral Direction Direction of the Funeral Dir		29a. Certifier 1 XCertifyir	buildin	g, etc. (Specify) best of my knowledge, sis of examination and	death	occurred at the time	e date and place a	City or Tow	vn, State) and manner as	bates
	To the He within 24 To the Fe completel	Medical	29b. Signature and title of certifie	and mann	er stated.	POI INVE	29c. License	number		29d. Da	te signed (Month	, Day, Year)
	12		30. Name and address of person JAMES P. BROWN	,	of death (Hern 23a) (rint)		CIZITE			
	Sta Registr	46.2	31. Date filed (Month, Day, Year) MAR 1 5	32. Re	gistrar's Signature		Sporks	DRIVE, RO	······································	⊑ , _M	ıu 20850	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#1,3/11/0 Health and Mental Hygiene Certificate of Death

Reg. No. 2004 09979

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Discontint		 Decedent's Name (First, Middle, 							2. Date of Dea		Vaa	3. Time of D	Death
Physici /Medio		Daniel Martin	Poloviek	Palov	ick				MANN	Day	, 200		DA M
Examir		4a. Facility Name (If not institution,	give street and number	')		4b. City, Tow	n, or Locatio	n of Death	7 7 7 7	1 /	County of De		/4
		643 Knights Is	land Road			Cecil	on			C	eċi1		
Funeral		5. Social Security Number		ge (In yrs. I	last birthday)	If Under 1 Ye		er 24 Hrs.	8. Date of Birt	h Vaaal	9. B	inthplace (State or	Foreign
Director		175-36-9667	¹X M 2□F 5	57	Yrs.	Months Da	ys Hour	s Min.	8. Date of Birt (Month, Da Oct. 9,	194	6 Pe	ennsylvan	ia
<u> </u>		Usual Residence of Decedent											
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a-fa	ţō	Maryland Cecil			Cecilt	con						1 🗆 Yes 2	2 □ No X
h the	ie	10e. Street and Number				10f. Zip Cod	8			10g. Citiz	en of What C	Country?	
h wil	by Funeral Director	643 Knights Isla	and Road			2	1913			USA			
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Ment Ment arked	2	Daniel Polovick					Con	cetta	Muriel	1o			
s me		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Stre	et and Num	ber or Run	al Route Numbe	r, City or	Town, State,	Zip Code)	
afth 27 i		Douglas Polovick	son		125 E	E. Nield	s St.	Apt.	5 West	Ches	ster.	PA 19382	
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Physician /Medical		disease or condition resulting in death)	_a. A50	- V I	·							1/2015	
Examiner		, , , , , , , , , , , , , , , , , , , ,	Due to (or as	s a consequ	ience of):								
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To the Hospital or Attending Physician: within 24 hours after death. To the Funerei Director: After this certifical completely filled in by the funeral director, to		29a. Certifier 1☐ Certifying	Physician: To the best	of my know	vledge, death	occurred at the	time, date a	and place, a	and due to the c	ause(s) ar	nd manner a	s stated.	
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		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type 1	Print)	7/7			1 ave	4)	204	
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Physici	an	JAMIYAH	ROBINSON	Month MARCH	6, 2004	0514 A
/Medic	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	144011	4c. County of Death	
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Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 2 15	8. Date of Birth (Month, Day, Y	eer) Cou	plece (Stete or Fore
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23a or 28a-f ehow wat be notified at	Funeral Director	10e. Street and Number 3430 Brinkley Rd. # 103	10f. Zip Code 20748	10g	. Citizen of What Cou	intry?
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Hygi other	C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Sumame)	
ked (To Be	James Robinson	Danielle	Mc	Bride	
lith and N 27 le mar r traumai		19a. Informant's Name/Relationship (Type, Print) Danielle McBride, Mother 19b. Ma 3430	iling Address (Street and Number or Rum Brinkley Rd. # 103 Tem	al Route Number, Cole Hills,M	City or Town, State, Zi D. 20748	ip Code)
Department of Health and Mental Hygiene important: If Item 27 le marked other than "n eny injury or other traumatic event, <u>tra Meal once.</u>		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	ematory or other place) 3_13.		c. Location - City or T Indover, MD,	
Departm Importa eny inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Bianchi F.S. 814 Upshum	St. NW Was	h. DC 20011	
ysician Medical was pricial and provide transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sudden Infant Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	J. L. L. L. L. L. L. L. L. L. L. L. L. L.			
the attending pl	by Physician/Med		B⊟Ectopic pregnancy G Other (specify)		23d. Date of delive Month	rery Day Year
pe de		Part II. Other significent conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute lo	the cause of death
ate has been si page 2 should	Completed			24a. Was an autopsy performe	prior to co	opsy findings avail ompletion of cause 2 No
= -	Be	25. Was case referred to medical examiner?	Othor	h (Check only one)		
ertific ector,	10	NOTES 2 NO 1 Inpatient ZALS ENVOUTPAT	ent 3 DOA 4 Nursing Ho	me 5 Residence 28d. Describe how	injury occurred	ify)
this certificate al director, pag	5	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time Injury		200. D03(1100 110W	inquity occurred	
h. After this funeral di	Ħ		street factory office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
or death. ctor: After this by the funeral di	Sertification	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	311001, 123101 <i>y</i> , 311100	-		
24 hours after death. Funerel Director: After this etely filled in by the funeral director.	edicai Certification;		ath occurred at the time, date and place,	and due to the caused at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
h. After this funeral di	Medicai Certificatio	4 Homicide determined determined determined 29a. Certifier (Check only 37 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place,	red at the time, date	and place, and due	to the cause(s)

			1 - For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artment of H rtificate of	lealth an <i>Death</i>		jiene (leg. No.	2004	09981
			1. Decedent's Name (First, Middle, L	ast)					2. Date of Dea Month	th Day	Yeer	3. Time of Death
	Physici /Medio			Parpat:	i Ramch	andani			March		2004	5:10 PM ^M
	Examir		4a. Facility Name (If not institution, g.	ve street and nu	m <i>ber)</i>		4b. City, Town, o	r Location of E	Death	4c. C	ounty of Death	
			Mariner Health	Care of	Bethes	da	1	3ethesd	а		Montgo	mery
	Funeral Director			Sex 1 ☐ M 2 🕅 F	7. Age (In yrs. 92		If Under 1 Year Months Days	If Under 24	Min. 8. Date of Birtl (Month, Day Sept. 1	, Year) 9, 19	9. Birth Cou Pal	place (State or Foreign intry) Kistan
	D .		Usual Residence of Decedent		10- 0							and toolds Obsticate
	how	_	10a. State 10b. County		TOC. CI	ty, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 1 No
	Ba-f	cto	Maryland Montgom	ery		Poto						
	iih th	Oire	10e. Street and Number				10f. Zip Code			10g. Citize	on of What Cou	intry?
	23e	Tai	9228 Cambridge	Manor Co	ourt		208				ted Sta	
	r deg	Ine	11. Marital Status	Armed Fo		.S. 13.	Was Decedent of I f Yes, specify Cub	lispanic Origin an, Mexican, P	? (Specify Yes or No- Puerto Rican, etc.)	14	 Race - Amer Black, White 	
36	or li	y F	1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	ve		1 ☐ Yes 2 ☑ No	Specify:		S	pecify: A a i	an-Indian
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23e or 28e-f ehow the Madical Examiner must be notified at	D D	3 ☑ Widowed 4 ☐ Divorced	Year or D	eates:	162 Docor	dent's Usual Occur	ation			AS I	
5	"nat	Completed	15. Decedent's l (Specify only highest g			(Give	kind of work done DO NDT use retire	during most of	f working	160. Killo	or pusinessyn	lousity
12	within	m.	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker	-,		Ошт	1 Home	
2	filed Hygi ther ont, I	Ö	17. Father's Name (First, Middle, Las	it)				18. Mother's	Name (First, Middle,			
Maryland	d be ental	To B	Hardasmal Malka	ni				н. (Chablani			
2	mari mati	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street		or Rural Route Numbe	r, City or 1	Town, State, Zi	p Code)
2	nd 2 :		Chander Ramchand	ani/Son		9228	Cambrid	e Manor	Court, Pot	omac	. Marvl	and 20854
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-f show many injury or other traumatic event, the Madical Examiner must be notified at once.		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other pla				ation - City or T	
9	Page ages		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		State Mor	ntgomer	um Inc.	Ma 20.	arch 2004	Ret	heeda	Maryland
	artm ortar injut		21. Signature of Funeral Service Vic		1016							
Ba	Dep Imp		1 Karton		M001	198 B	ethesda-(Chevy C	hase, Inc. nd 20814-3	7557	7 Wisco	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	mplications that of			er the mode of dyir	ng, such as car	rdiac or respiratory are	est,		Approximate Interval Between
	Physician		Immediate Cause (Final				Bronchit					Onset and Death
	/Medical		disease or condition resulting in death)	_ a	(or as a conseq		BIORCHIL	12				
	Examiner			Chr	onic B	conchia	ıl Asthma					
热歌 。		ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseq	uence of):						
	cuted	Examiner	that initiated events	C.			tial Lun	g Disea	ase			
0,	e exe ien a urial-	Ě	resulting in death) Last	Due to	(or as a conseq	puence of):						
8760,	icate be executed physicien and s the burial-transit	dicai		d								
9	eath certific attending pl	0	IF FEMALE:	220 If year out	some of progn	2004						
Вох	ath c	Physician/M	23b. Was decedent pregnant in the past 12 months?	1☐Live t	tcome of pregna pirth 2 Feta	Ideath 3	Ectopic pregnancy	1		230	d. Date of delive Month	ery Day Year
0	at the de by the a tached f	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4∐Pregr 9∐Unkn	ant at time of down	eatn 5∟	Other (specify) _					
<u>α</u>	hat the sed by detac		Part II. Other significant conditions	contributing to d	eath but not res	ultina in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
ds,	signed I	d by	Old Age	_		-	, , ,		1 □ Y	es 2 😿 I	No 3 ☐ Pro	bably 4 Unknown
Ö	w requir been si should I	etec	Generalized Se	vore Dee	onorati	IIO Art	hritia		24a. Was a	_ I	Odb Wass sub	opsy findings available
Records,	e la has	Completed by							— autops perfor	ned?		impletion of cause of
a			Hypertension,	Diabetes	Mellit	us Typ	e II	00.01 /	1 ☐ Yes	2 X No	1 🗆 Yes	2□ No
Vital		Be	25. Was case referred to medical examiner?	Hospital:		ED/O	. aClass Ott		Death (Check only or		70 (0	
of		- T	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time of			ng Home 5 Residence 128d. Describe he			(y)
on	ding Phi th. After thi funeral	tior	1 X Natural 5 ☐ Pending 2 ☐ Accident investigati		th, Day Year)	Injury	Woi M 1□	k? Yes 2∐No				
Division	l or Attending after death. Director: After in by the fune	fica	3 Suicide 6 Could not	be 28e. Place	of Injury - At h	ome, farm, str	eet, factory, office				Number or Run	al Route Number,
ò	after Direction by	Certification:	4 Homicide	buildi	ng, etc. (Specil	γ)			City or Town	n, State)		
	To the Hospitel or within 24 hours afte To the Funeral Direction completely filled in the Funeral Direction of the Funera	Medical C	29a. Certifier 1 X Certifying F (Check only one)	miner: On the b	best of my kno asis of examina ner stated.	owledge, death	occurred at the tirvestigation, in my c	ne, date and p pinion, death o	place, and due to the coccurred at the time, d	ause(s) ar ate and pl	nd manner as s lace, and due t	itated. o the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date s	signed (Month,	Day, Year)
	nsho		Wygran	2120	M.D.		1 21	662		3.6	mah 17	2004
	2		30. Name and address of person who			n 23a) (Type.		40		ма	rch 16	, 2004
			Wilhelmina G. Ca					Rockv	ille. Marv	land	20853-	3106
	Sta		31. Date filed (Month, Day, Year)	32. P	legistrar's Signa		Ana V	1				

			1 - State of Maryland / De Registrar	partment of Health and Mertificate of Death	Mental Hygi	ene 2004	09982
			Decedent's Name (First, Middle, Last)		2. Date of Death Month)	3. Time of Death
	°Physici /Medic		Sylvia Ann Richardson		March	17 2004	7:00 P ^M
-	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
) %.	98	Holy Cross Rehab. and Nursing Cente: 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdi		T 0 5 11 (5 11)	Montgome	·
П	Funeral Director		5. Social Security Number 6. Sex 184-32-4160 6. Sex 64 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Jan. 13,	Year) Con	place (State or Foreign untry)
	D		Usual Residence of Decedent		Jan. 13	, 1940 Per	nsylvania
	nytan	_	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Be-fe	Director		Spring			1 ☐ Yes 2 🛣 No
	with the	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	untry?
	s 23g	Funeral	1709 Nordic Hill Circle 11 Marital Status 12. Was Decedent Ever in U.S. 1	20906	if . V N	USA	to a dead
	ter d	-un	11. Marital Status 12. Was Decedent Ever in U.S. 1 Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	14. Race - Amer Black, White	
93	urs a	by	3 ☐ Widowed 4 ☒Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Wh	ite
5	within 72 hours after death with the Maryland ene. then "neturel", or Items 23s or 28e-f ehow the Marited Examiner must be multired at	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work	ring 1	6b. Kind of Business/li	ndustry
2	vithin ne. hen "	mple	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ang .		
2	iled w dygier ther th		17. Father's Name (First, Middle, Last)	gistered Nurse	a (Final Adiabetta Ad	Health (Care
Maryland 21215-0036	to be i	Be	Sam Parziale		e (First, Middle, M	aiden Sumame)	
7	shouk nd Me mark metik	To		ailing Address (Street and Number or Run	Caruso	City or Town State Zi	n Code)
\leq	nd 2 alth author 27 is			9 Nordic Hill Circ			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23s or 28e-f ehow eny injury or other treumetic event, it was marked at some Examiner must be multiled at once.		20a. Method of Disposition 20b. Place of Dis	sposition (Name of		Oc. Location - City or T	
E	Page Int: If		Deliai 2 Acientation 3 Hemoval non State	Litan Crematory 20		Alexandria	Virginia
alti	permit. Departri Importe eny inju		21. Signature of Funeral Service Lice isee	22. Name and Address of Facility Trancis J. Collins			VIIIII
<u> </u>	89 = 9		John C. Jayer	000 University Blvd	. W., S1	lver Spring	MD 20901
П			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or leart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	Pnysician	ı	Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructi	ve Pulmonary Disea	se- End S	Stage	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate b. Morbid Obesity Due to (or as a consequence of):				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	on			
o,	execan an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):		·		
8760,	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dlcal	d. <u>Diabetes Mellitus</u>				
9	Jeath certific attending pl	0	IF FEMALE:				
. Box	attenc for us	ian	A Brognant at time of death	3 □Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
P. O.	that the death cered by the attendin	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)			
σ.	res that signed b	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
rg	w require been sig should b	ed b	Depression, Hypertension, Hyperlipi	demia	1 🗆 Yes	2 ☐ No 3 ☐ Prof	oably 4xxunknown
000	law requas been 2 should	plet			24a. Was an	24b. Were auto	ppsy findings available impletion of cause of
m m	The ate ha	Completed			autopsy performe 1 Tes 2	ed2 death? No 1 ☐ Yes	
Vital Records,	ysicien: The law is certificate has b director, page 2 s	Be (25. Was case referred to medical examiner?		h (Check only one)		
of	Physi this c	2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			ce 6 □Other (Special	(y)
Division of	ding I	tlon	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation 2 □ Accident		28d. Describe how	injury occurred	
isi.	deatl deatl ctor: y the	fical	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		28f. Location (Stre	et and Number or Rura	al Route Number
2	after after I Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)	,,,	City or Town,	State)	
	ospit hours unere ly fille		29a. Certifier (Check only Check only 2 Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place,	and due to the cau	se(s) and manner as s	tated.
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifics completely filled in by the funeral director, I	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	Investigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
	Son With	Σ	29b. Signature and title of certifier	29c. License number	29d	l. Date signed (Month,	Day, Year)
	5		Saima Managn	D00058965		March 18,	2004
			30. Name and address of person who completed cause of death (Item 23a) (Typ Saima Khawaja M.D. 11119 Rockville		D = 1 +1 1	10.000	
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Pike, Suite 100,	VOCKA1TT	e, MD 208	52
	Registr		MAR 1 9 2004	Sparks			

		•	1 - For State Registrar	State of Marylar	nd / Dep <i>Ce</i>	artment of F ertificate of	lealth and N <i>Death</i>	fental Hygie Reg	ne 200	4 09983
ľ			1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		FREDERICK	RI	CHFIEI	LD .			2004	10:08 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	ath
			HOLY CROSS HOSPITA		to at hinth day	SILVER S			MONTGOME	
	Funeral		5. Social Security Number 6. S	MM 2 F	16 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y)	ear) C7F(rthplace (State or Foreign country) CHOSLAVAKIA
	Director		578-56-3683 Usual Residence of Decedent	C				12/2//19	17 CAEC	DIOSLAVAKIA
	yland yland		10a. State 10b. County	10c. Ci	ty, Town or L	.ocation				10d. Inside City Limits
	B-f sl	ctor	MARYLAND MONTGOME	RY SIL	VER SI	PRING				1 ☐ Yes 2 🎇 No
	or 28	Directo	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	ath w		3701 INTERNATIONAL			20906			.S.A.	
	er de Itams	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 No	1.5.	. Was Decedent of H If Yes, specify Cub	an, Mexican, Pu <i>e</i> rto	Rican, etc.)	14. Race - Am Black, Wh	
35	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show the Maryland Examination mat be molified at	by F	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🂢 No	Specify:		Specify: W	HITE
5-0036	n 72 hours "natural", edical Ex	ted	15. Decedent's Ed	lucation	16a. Dec	edent's Usual Occup	pation		b. Kind of Business	s/Industry
בן בנו	thin 7	Completed	(Specify only highest gra	College (1-4or 5+)	life.	e kind of work done DO NOT use retire	d) most of work	arig		
7	filed within Hygiene thar than ant, Ite M	Con	12		CLER	ζ			UPERMARKI	T
ב	g la b	Be	17. Father's Name (First, Middle, Last)		T 011 0 F	F 77 7 7		e (First, Middle, Ma	,	NATIO.
Maryland	2 should and Men Is marke aumatic	2	HENRY 19a. Informant's Name/Relationship (ICHSF		JANKA	ral Route Number, C	FLEISCHAC	
<u>a</u>	d 2 sl th an 17 ls r traur		KATARINA RICHFIELI		1			, SILVER	•	
	tand Health tam 27 pather to		20a. Method of Disposition	20b.	Place of Disc	osition (Name of ematory or other pla			c. Location - City o	
Ē	nit. Pages 1 and 2 should artment of Health and Men ortant: If Itam 27 Is marke injury or other traumatic g.		1 X Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	-			0/2004 FA	LLS CHURC	CH, VIRGINIA
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lices					L DIRECTI		, validativati
m	Depar Depar Impor any ir	. 11	STATE TOP)	10	091 ROCKV	ILLE PIKE	, ROCKVIL	LE, MD 20	1852
		1	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not er	nter the mode of dyin	ng, such as cardiac	or respiratory arrest	,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a DNEUMO	NIA					Onset and Death
	/Medical Examiner		resulting in death)	Due t (or as a consec						
	LXdiffiller	-	Sequentially list conditions,	b. MYDCARD Due to for as a conse		INEARCI	ICN			WEEKS
	ted nsit	nine	frany learling to immediate cause. Enter Underlying Cause (Disease or injury	CLOSTRIA		DIFFICE	e wiit	TS		DAYS
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a consec		DITITION	0002.			
8760	ficate be executed physician and s the burial-transit	dical		_ d						
ဖ	ntifica ng ph	Med	IF FEMALE:							
õ	death certifi e attending i ed for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	□Ectopic pregnanc	y		23d. Date of de Month	Day Year
C.	Δ a δ	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at time of o	death 5	Other (specify) _				,
<u>ď</u>	that the	Ph	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the	underlying cause giv	ven in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
ds,	w requires that the de been signed by the should be detached							1 □ Yes	2 No 3 □ P	robably 4 Unknown
Ö	w req been shou	lete						24a. Was an	24b. Were a	utopsy findings available completion of cause of
æ	nysician: The law requires that the nis certificate has been signed by the director, page 2 should be detached.	Completed						autopsy performe 1 ☐ Yes 2 2	d? death?	
ta	an: 1 rtifical	e e	25. Was case referred to medical				26. Place of Deat	th (Check only one)	ino i a io	2010
>	nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ⊠Inpatient 2□	ER/Outpatie			ome 5□Resid <i>e</i> nd	e 6 □Other (Spe	ecify)
0	or Attanding Physician: after death. Diractor: Atter this certifica in by the funeral director. I		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo		28d. Describe how	injury occurred	
<u>s</u>	Attandi er death ractor: A by the fi	cat	2 Accident investigation 3 Suicide 6 Could not b	e Oga Glace of Injury At h	omo form o		Yes 2 □No	28f Location (Street	at and Number or F	Tural Route Number,
Division of Vital Records, P.O. Box	after of Dirac	Certification:	4 ☐ Homicide determined	building, etc. (Speci	fy)	ileer, lactory, office		City or Town, S		orar noble nomber,
	within 24 hours after To the Funeral Directory completely filled in by		29a. Certifier 1 Certifying Ph	ysicien: To the best of my kn	owledge, dea	th occurred at the ti	me, date and place,	and due to the caus	se(s) and manner a	s stated.
	n 24 h n 24 h ha Fu pletely	edical	(Check only 2 Medicel Exer	niner: On the basis of examinand manner stated.	ation and/or i	nvestigation, in my o	opinion, death occur	red at the time, date	and place, and du	e to the cause(s)
	Tot	Σ	29b. Signature and title of certifier	in Anddy	M	29c. Licens			Date signed (Mon	
1	4			with reddy			3464	17,	ARCH-09-	2004
			30. Name and address of person who VIKLAMADITYA. D. R.	completed cause of death (Ite	m 23a) (Type したしたいご	e, Print) LE PILE, S	UDTE 208,	ROCKVILLE	, ND - 208	52
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sign						
	Regist	ar	MAR 1 5 20	04 Seneva	10	Spark				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene? 0.0

			1 - For State Registrar	State of N	laryland / De <i>C</i>	partment of Health <i>ertificate of Deatl</i>	h	giene2 () () (+ 09984
	Physic	an	Decedent's Name (First, Midd Thomas	(le, Last) Allen	Dag		2. Date of Dea Month	ath	3. Time of Death
Roy	/Medi	cal	4a. Facility Name (If not institution		Rog		March		
	Examir	ner	Mariner Hea			4b. City, Town, or Location Silver Sp		4c. County of Dea	
	Funeral		5. Social Security Number 7 1 3 2 - 0 9 - 3 3 9 7	6. Sex 7. A	ge (In yrs. last birthda		er 24 Hrs. 8. Date of Birth		rthplace (State or Foreign Country)
	Director			1) ØM 2□F	87 Yrs	World's Days Hours	Nov. 2	,1916 si	t.Mary's,PA
	land ow		Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or	Location			10d. Inside City Limits
	Man 9-1 sh	tor	VA. Alba	amarle	Charl	ottesville			1 ☐ Yes 2 🔀 No
	th with the Marylan 23a or 28e-f show ust be multified at	ai Dire	10e. Street and Number 884 Ashley	Court		10f. Zip Code 22901		10g. Citizen of What C USA	Country?
Maryland 21215-0036	ours atter des rei', or items Examiner o	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mai 3 ☑ Widowed 4 □ Divorced	If Ves Give	? No 942	Was Decedent of Hispanic O If Yes, specify Cuban, Mexica □ Yes 2⊠ No Specify		14. Race - Am Black, Whi Specify: Wh	ite, etc.
5-("natu	etec	(Specify only highe	nt's Education est grade completed)	16a. De (Gi	cedent's Usual Occupation we kind of work done during mo . DO NOT use retired)	ost of working	16b. Kind of Business	s/Industry
7	d within 72 ho piene. r than "natur the Madical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)			II G G	1 上
<u>d</u>	filec Hyg othe	Be C	17. Father's Name (First, Middle,		reu	eral Aviatio	ner's Name (First, Middle,	U.S.GOV Maiden Surname)	τ
/lar	Vental Mental Irked c	TO B	Henry J.Roga	an			Lola Allen	L	
lan,	2 sho and I is me	7. 7.	19a. Informant's Name/Relations			iling Address (Street and Numb			
e, ¬	1 and Health em 27 ther t	1 8	Arleen P.Roga 20a. Method of Disposition	an/Daughte		806 Notley R			
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic events.		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (5	Specify)	Holly	Mem. Gardens	3/17/04		esville,VA
Baj	permit Depar Impor any in		21. Signatur of Funefal Service	Weeken -	F	PARTA Address of Facility of Part Address of Part Address	ALDI FUNERA a Blvd.Silv	L SERVIC	E,P.A. g,Md20910
1	Physician		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	r complications that cause only one cause on each I	d the death. Do not e	nter the mode of dying, such as	s cardiac or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner			Due to (or as	a consequence of):				
-	<u>ت</u> و	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a cursequence of).				
	xecute and il-trans	Examiner	that initiated events resulting in death) Last	c	a consequence of):				
68760,	iticate be executed to physician and as the burial-transit	ledicai E		d					
			IC COM C						
.O. Box	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of del Month	ivery Day Year
ď.	ss that gned b	by Pi	Part II. Other significant condition	ons contributing to death b	ut not resulting in the	underlying cause given in Part I	I. 23e. Did tob	acco use contribute to	the cause of death?
ğ	w requires t been signe should be	ted					1 🗆 Ye	s 2 No 3 Pr	obably 4 Dunknown
Vital Records,		Completed					24a. Was ar autops perform 1 Ves 2	y prior to death?	itopsy findings available completion of cause of
Z Z	ding Physicien: h. Atter this certific funeral director.	Be	25. Was case referred to medical examiner?	Hospital:		0#	e of Death (Check only one		
ō	hy l d	5	1 Yes 2 XNo	1 ☐ Inpatie			ursing Home 5 Reside		cify)
on	Attending Physicien: r death. sctor: Atter this certific. by the funeral director.	tion	1 Matural 5 ☐ Pendin 2 ☐ Accident investig	g (Month, Da	y Year) Injury	of 28c. Injury at Work? M 1 □ Yes 2 □	28d. Describe ho	w injury occurred	
	or Attendate death Director:	Certification:	3 Suicide 6 Could a 4 Homicide determ		ury · At home, farm, s		28f. Location (Str	eet and Number or Ru	ral Route Number,
ā	ital or A	Cert	TOTAL	Dundary, et	c. (apecity)		City or Town,	. State)	
	To the Hospital or At within 24 hours atter of to the Funeral Directompletely tilled in by	Medical	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the best Examiner: On the basis of and manner sta	examination and/or i	th occurred at the time, date an nvestigation, in my opinion, dea	nd place, and due to the car ath occurred at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifie	116	1	29c. License number	2 //	d. Date signed (Month	n, Day, Year)
(DY	-	30 Name and addition of	MALLER	14.)	00703	77	5/17/20	04
			30. Name and address of person BARK TO 31. Date filed (Month, Day, Year)	SUBARM		120 FARRYEL	UT AVE KEN	13105/100,	ND 20895
	Stat Registra		MAR 15		ars signature	Sparke			

				State of M	aryland			т неакп an of Death	nd Mental Hy	/giene Reg. No. 2 (nnl	09985
	***		1. Decedent's Name (First, Middle, La	st)					2. Date of D	eath	3	. Time of Death
	Physicia		Frances Agne	s Rooney					Month March	Day 17, 200	Year	6:45 pm
100	/Medic Éxamin		4a Facility Name (If not institution, giv					4b. City, Town	, or Location of Dea			O'45 Tm
-/-	Examini	21	Montgomery Hosp			2		Rock	ville	Mont	gomery	
	Formul		5. Social Security Number 6. S		e (In yrs. las		If Under 1 Y	ear If Under 24	Hrs. 8. Date of B	irth		(Stete or Foreign
п	Funeral Director			I ☐ M 2 🖾 F	95	Yrs.	Months Da	ys Hours	Min. (Month, D	ay, Year) 17 , 1908	Country)	icah PA
		ŀ	Usual Residence of Decedent						вере.	17, 1700	Difchaire	doan, IA
	/lend		10a. State 10b. County		10c. City, 7	Town or Loc	ation				10d.	Inside City Limits
	Man	ğ	Pennsylvania Schu	ıylkill	Sh	enand	nah					1∐Yes 2⊠No
	158 th	8	10e. Street and Number	-)		·	10f. Zip Coo	de		10g. Citizen of	What Country?	
	E S K	Funeral Director	419 W. Lloyd Str	eet			1797	76		USA		
	eath F 23	era	11. Marital Status	12. Was Decedent	Ever in U.S.	13. W			? (Specify Yes or N		e - American I	ndian,
_	in the state of th	5	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯					n? (Specify Yes or N Puerto Rican, etc.)	Bla	ck, White, etc.	
20	S 8	اڇ	3 Nidowed 4 Divorced	If Yes, Give Year or Detes:		1	☐ Yes 2점	No Specify:		Specif	White	
21215-0020	filed within 72 hours after death with the Marylend Hygiene. ther than "naturel", or fleme 23a or 28e-f ehow ent, the Medical Examiner must be notified at	Completed by	15. Decedent's E	ducation		16a. Decade	ent's Usual Oc	cupation		16b. Kind of B		ry
15	in 7	흥	(Specify only highest gra	ide completed)		(Give k life. D	kind of work de O NOT use re	one during most of tired)	f working			
7	withir iene. then	Ē	Elementary/Secondary (0-12)	College (1-4or	0+)	Hom	emaker			0	wn Home	2
D	be filed withintal Hygiene. d other than event, the M	ပ္	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Surnan	10)	
an		To Be	II					Mary	y MacStud	Ís		
Maryland	d 2 should be filed th and Mental Hygis 7 le marked other traumatic event, II	F	Unknown Denay 19a. Informant's Name/Relationship (19b. Mailing	Address (St		or Rurel Route Numi		State. Zip Cod	de)
Z	12 a 7	- 1										MANUAL STREET
	of Health Item 27 I	ŀ	Christopher J. Ro 20a Method of Disposition	oney/ Son	20b. Plac	e of Dispos	ition (Name o	f	Lane, Bro	20c. Location		
ğ	8 4 = 1		1 ☐ Burial 2 ☐ Cremation 3 5		cem	netery, crem	atory or other	place)	March 19	g	-	
Baltimore,	permit. Pege Department of Important: if any Injury or pncs.		4 Donation 5 Other (Specif		Annun	ciatio	on BVM	Cemetery	, 2004	Shenand	oah, Per	nnsylvania
3a	Depar mpor mpor any in	- 1	21. Signature of un ral Service Licer	1See		Fr	Name and Ad ancis	dress of Facility J. Colli	ns Funera	1 Home T	nc.	
	90 = 9		XMUT /1	Shin .					1vd. W.,			MD 20901
	775		23a. Part1. Friter the sease, or me shock, or heart failure. List only	cations that caused	the death.							oroximate erval Between
	Physician		Shook, of hour failure. Elst only	2110 04400 011 04011 11							On	set end Death
-/	/Medical		Immediate Ceuse (Final disease or condition	Advanc	ed Dem	nentia					Le	ss than Year
	Examiner		resulting in death)	a	Due to (or a						1 1	leal
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	ficete be executed physician and as the burial-transit	Examiner	Sequentially list conditions	b	Due to (or e	s e consequ	ience of):					
oʻ	an ar rial-tr	à	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events									
68760,	sicie bu	edical	Ceuse (Disease or injury that initiated events	C	Due to (or as	s a consecu	ence of):				-	
		8	resulting in death) Last			,	,				į	
Вох	lew requires that the death certificate been signed by the ettending as been signed by the ettending as 2 should be deteched for use as	Physician/M		d							<u> </u>	
	d for	S	Part II. Other significant conditions of	ontributing to death b	ut not resulti	na in the un	derlying cause	given in Part I	23b. Did	tobacco uae co	ntribute to the	cause of death?
P.0	res that the de signed by the e be deteched i	Ş	Tatti. Other algimicant conditions o	onthibuting to doutin b	at not resulti	ng in the an	donying dass.	givon in tace.		Yes 2⊠ No		y 4 □ Unknown
	that ned b	<u>~</u>	Cerebrovascular	Accident					''-	168 222110	5_110 5a 5i	y 4 onkilowi
of Vital Records,	uires sigr ld be	d b							24a. Wa	s an autopsy		utopsy findings
Ö	been shoul	Completed							perf	ormed?	comple of deat	le prior to
Re	0 - 0	윤							0249	AND MAKEUM		
<u>_</u>	: The le cete ha r, page 2									Yus 2XNc	1 ∐ Ye	s 2 No
<u> </u>	Physician: The this certificate rel director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Other:	Death (Check only			
5	hy le le	၉	1 ☐ Yes 2 ☑ No 27. Menner of Death	1 linpatie	ent 2□EF			4 LI INUISII	ng Home 5 ☐ Res			ospice
	Ing F	5	1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da		Bb. Time of Injury		njury at Work?		how injury occur	190	
Division	Attending or death. ector: After by the fune	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b					1 ☐ Yes 2 ☐ No		/Ca a4 a d 81 4	D / D	and Alicenter
≥	r At fred irect n by	틭ㅣ	4 ☐ Homicide determined	28e. Place of Inj	ury - At nome c. <i>(Specify)</i>	e, tarm, stre	et, ractory, off	ICO		(Street and Numb wn, Stete)	er or Hurai Ho	ute Number,
Ω	Hospital or 24 hours afte Funerel Dir Mely filled in	ပီ										
	thor thor une ely fi	edical	(Check only 2 Medical Exar	yalclan: To the best on the basis of the bas								
	a in the	2	one)	and manner sta	ated.							
	With To To To To To To To To To To To To To	Σ	29b. Signature and title of confifier	MIL.			29c. Lic	ense number		29d. Date signe	a (Month, Day,	reer)
•	in		CESOS				<u> </u>	1004	1218	3/48	104	
-	U		30. Name and address of person who	completed cause of d	eeth (Item 23	3a) (Type, P	rint)	111		7	7	
			Charles Harrison	M.D. 600	l Munc	aster	Mi11	Road, Roc	ckville, N	1D 20855		
	Stat	e	31. Date filed (Month, Day, Year)	04 32. Registr	ar's Signatur	9	lone	41	-			

DHMH 16 Rev 6/95

		1 - For State Registrar	State of M	laryland	d / Depa <i>Cei</i>	artmen <i>tificate</i>	t of H	ealth and Death	d Mental F	lygier Reg. I		04	09986
Physicia /Medic		1. Decedent's Name (First, Middle, Las. Oscar Ruiz	•						2. Date of Month March		Day 20	Year 04	3. Time of Death 2:50 P M
Examin	er.	4a. Facility Name (If not institution, give Suburban Hospit	:a1			Bet	hesd					of Death gome	ry
Funeral Director		5. Social Security Number 6. Se 460-95-1080 15 Usual Residence of Decedent	X M 2□ F	ge (In yrs. Ia 56	Yrs.	Months Months	1 Year Days	Hours N	lin. 8. Date of (Month, Sept.	Birth Day, Yea 19,	1947	9. Birthp Court Cub	place (State or Foreign htry) a.
Maryland a-f ehow	tor	10a. State 10b. County Maryland Montgom	ery		Town or Lo		illag	ge				1	0d. Inside City Limits 1 ☐ Yes 2 No
ath with the 23a or 28 ust be not	Funeral Director	10e Street and Number 19108 North Kindl	y Court			10f. Zip	Code 0886			-	Citizen of W		,
5-0036 72 hours after death with the Maryland natural", or Hems 23a or 28a-f show actal Examiner must be nutified at	þ	11. Marital Status 1 ☐ Never Married 2 ※ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 X If Yes, Give Year or Dates:	?	J.	Vas Deced Yes, spec	ify Cubar	, Mexican, Pu	(Specify Yes or erto Rican, etc.) uban	No-		k, White,	an Indian, etc. ite
121 within ene.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or	5+)		lent's Usua kind of word DO NOT us Ltric	k done du e retired)	tion uring most of a			Kind of Bu	siness/Inc	dustry
Maryland 2 d 2 should be filed th and Mental Hygi t? is marked other traumatic event,	To Be Co	17. Father's Name (First, Middle, Last) Rafael Ruiz	2		GELLE	LLIC		18. Mother's N	lame (First, Midd a Luisa	lle, Maide	en Surname		ile
C = 17		19a. Informant's Name/Relationship (7) Anita Ruiz / Wif	•	got Bi-	19108	Nort	h Ki			gome	ry Vi	11ag	e, MD 2088
Page Page		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service Licens	A	cer	ce of Dispos netery, crem	catory or other constants. Ceme	her place etery	20	ch 17,	Gen		own,	wn, State Maryland
Balt permit. Departr Importa any injig		1/ Jung C.	M	The death	10	E. D	eer	Park D		hers	l Home burg,	MD	
Physician /Medical Examiner		23a. Part1. Enter the dispase, or complete shock, of wheart failure. List only of Immediate Cause (Final disease or condition resulting in death)	1,000,000,000	THIST	MC				CARC		MA	_0	Approximate Interval Between Onset and Death
D, executed in and rial-transit	edical Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
Box 6 death certiff death certiff e attending d for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3	Ectopic pre Other (spe					23d. Date Mont		y Day Year
	δ	Part II. Other significant conditions con					use given	in Part I.				oute to the	e cause of death?
The The page	Completed	RENAL FY	HIURE	·						is an opsy formed?	pr de	ere autop or to com ath?	sy findings available pletion of cause of
of Vita Physician: this certific	0 126	25. Was case referred to medical examiner? 1 Yes 2	lospital:	ent 2 🗆 EF	NOutpatient	3 🗀 DOA	Othor		eath <i>(Check only</i> Home 5 Re		6 MOther	(Specify)	
Division of a or attending Physical after death. Director: After this in by the funeral of the		27. Manner of Death 1	28a. Date of Inju (Month, Da	y Year)	8b. Time of Injury	28 M	c. Injury a Work? 1 Ye		28d. Describe				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the it	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	c. (Specify)					City or To	own, Stat	te)		Route Number,
To the Hospital of within 24 hours at To the Funeral completely filled in	edical	29a. Certifier 1 Certifying Physical Check only onle) 2 Medicel Examination	sician: To the best ner: On the basis of and manner sta	r examinatio	edge, death n and/or inve	occurred at estigation, i	the time, n my opin	date and placi ion, death oc	ce, and due to the curred at the time	e cause(s o, date ar	s) and mani nd place, an	ner as sta d due to t	ted. he cause(s)
	M	29b. Signature and title of certifier	Wa ma				License r				ate signed		
b		30. Name and address of person who to		eath (Item 2	3a) (Type, P	rint)	225	- 00	<i>#</i> 1.	MA	1114	15,	2004 40 20817
State Registra		31. Date filed (Month, Day, Year) MAR 1 7 20	32. Registra	ar's Signatur	° L	Soo	W/se	, //K.	# 4100	B	CTHES	DA, I	40 20817

RUIZ, OSCAR 3-14-04 1450

Physician /Medical **Examiner** or Attending Physician: The lew requires that the deeth certificate be executed

copertment of Heelth and Mental Hy Important: if I tem 27 ie marked othe any injury or other traumand

Peges 1 and 2 should be filed within 72 hours efter death with

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

NONE

10a. State DC NONE

Director

Funeral

δ

Completed

Funeral

Director

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Men 25. Wa exa

3 Suicide

29a. Certifier

4 Homicide

Examine edical Certification: To Be Completed by Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Resection of right Frontel maningiona Intracerebral hemorehage

Check only one)

1.661611 91113				
25. Was case referred to medical			26. Place of De	eath (
examiner? 1 Des 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient	3□ DOA	Other: 4 Nursing	Home
27. Manner of Death 1 Natural 5 Pending investigation 2 Accident	28e. Date of Injury (Month, Day Year) 28b. Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐ No	286

(Month, Day Year) 5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 ☐ Residence 6 ☐ Other (Specify)

29b. Signature and title of certifier W.S	. Anderson,	

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

William S. Anderson, John Hopkins Department of Neurosurgery, 600 North Wolfe Street, min

Registrar

31. Dete filed (Month, Day, Year) MAR 1 9 2004 32. Registrar's Signature

within 24 hours efter death.

To the Funeral Director: After thi
completely filled in by the funeral

within 2 To the

		_	For State Registrar	State of Marylan			nt of Healt te of Dea		F	Reg. No.	2004	
er in	Physici		Decedent's Name (First, Middle, Last) Su:	zanne RAPPOPO	RT				2. Date of Dea Month March 1		2004 Year	3. Time of Death 8:20 A M
	/Medic	1.00	4a. Facility Name (If not institution, give s			4b. City	, Town, or Locat	tion of Death		_	County of Death	
			Springhouse Assis	ted Living			lver Spi			N	lont gome	
	Funeral		5. Social Security Number 6. Sex	M 2XIF	last birthday) Yrs.	Months Months			8. Date of Birtl (Month, Da)	(, Year)	Cou	place (State or Foreign ntry)
	Director		144-36-4624 Usual Residence of Decedent	56		1			March /	, 19	948 New	Jersey
	anylan ahow	Ę.	10a. State 10b. County		y, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28e-1	Director	Maryland Montgome:	Гу	Silve		p Code			10a. Citiz	en of What Cou	
	3a or		2201 Colston Drive	#609 – E		1000	20910		1		ed Stat	
36	be tiled within 72 hours after death with the Maryland stal Hygiene do ther than "natural", or Itams 23a or 28e-1 ahow avant, the Mydical Examinat must be notified at avant, the Mydical Examinat must be notified at	by Funeral	11. Marital Status 1∑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2♥ No If Yes, Give Year or Dates:		Was Deco	edent of Hispanic ecify Cuban, Me:		ecify Yes or No- Rican, etc.)		4. Race - Ameri Black, White, Specify: wh	
9	2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Us	ual Occupation	most of work	na	16b. Kin	nd of Business/în	ndustry
21215-0036	within 7 ene than "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ork done during use retired)		, ig			
22	e filed within al Hygiene I other than vant, the Ma	Col	17. Father's Name (First, Middle, Last)	4	Fina	ncia	L Analys		(First, Middle,		Commerce	
au	should be nd Mental marked o	To Be	Wilson P. Ra	ppoport				Leslie	Marks			
Maryland	permit. Peges 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any injury or other treumatic ango.		19a. Informant's Name/Relationship (Ty									Code) 85253
S,	l and the tealth am 27 the tr		David M. Rappoport 20a. Method of Disposition	·					Lane, P		ise Val	
Baltimore,	nt of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Place of Disposemetery, crea							
altin	artme corten injur		21. Signature of Funeral Service License		2:	2. Name a	Cemeter and Address of F	acility	10 10 10		iff, NJ	
ä	Depariment Department		1	5			insky He erroll S				•	20012
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ications that caused the deat ne cause on each line.	h. Do not en	-	de of dying, suc	-		70	n, 50	20012 Approximate Interval Between Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	AD	RENAL	GLANI	Lyn	npH		34RS+
),	cate be executed physicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq		E,	LIVER	/170	0	bIXE	5	11 mos
8760	ate be hysicie	Ical	•	d								
.O. Box 68	death certiff e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Il death 3	⊒Ectopic ⊒ Other (s	pregnancy			2	3d. Date of deliv	ery Day Year
<u>α</u>	requires that the de neen signed by the hould be detached	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	rnderlying	cause given in F	Part I.	23e. Did to	_	se contribute to t	the cause of death?
Records,	e law has b je 2 s	Completed									24b. Were auto prior to co death? 1 □ Yes	opsy findings available impletion of cause of
Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:					(Check only o			
of	this aldie	lon: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	-	OA Other: 4 28c. Injury at Work?		me 5 Resid		Other (Special occurred	fy)
Division	To the Hospitel or Attanding I within 24 hours after death. To the Funerel Director: Atter completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st				28f. Location (S City or Tow		Number or Run	al Route Number,
	the Hospitel hin 24 hours a the Funerel hpletely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deal ation and/or in	th occurre ovestigation	d at the time, dat n, in my opinion,	te and place, , death occurr	and due to the deed at the time, d	ause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
	To the within 2 To the complet	2	29b. Signature and title of certifier	11. 0.	0		9c. License num		- 1		signed (Month,	
,	10		* Caretyn 1	Humm	Unes P		03723	76	/	NAZ	CH 11,	2004
	(30. Name and address of ferson who co	ENDRICKS 1	117 (Print)	ROLL	enge.	DR	Ber	CH 17, 7HE3DA	20817
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 18 20	32. Registrar's Signature 1	ature &	1	oaks					

Derek D. Rawlings 04-1863 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amand Item #1,8,28a per me C83: 4/19/04 tas
State of Maryland, Department of Health and Mental Hygiene
1- State Amend Item #21, per DVR, G829, 3/31/20/4, gap
Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item #1,8,28a per me C83: 4/19/04 tas
State of Maryland, Department of Health and Mental Hygiene
Certificate of Death
Registrar Reg. No. 2004 1. Decedent's Name (First, Middle, Last) Derek Devarice Rawlings 2. Date of Death 3. Time of Death Month Day **Physician** Derek Davanice Rawlings **February** 18 2004 02:10 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Hospital N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 4/15/64
Months Days Hours Min. (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** XÓM 2□F 39 Yrs. 1964 Washington, D.C Director 577-96-1874 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location Show 10a State 10b. County 27 is marked other than "netural", or items 23s or 28s-f shov traumatic sysut, the Mudical Examinar must be notified at 1 XYes 2 No MD Prince George's Forestville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2505 Wintergreen Avenue 20747 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Item sny injury or other traumatic syent, the Medical Exam 1X Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Laborer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Larry Crider Rosa Rawlings ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2505 Wintergreen Ave. Forestville, MD Rosa Crider 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial * 4 ☐ Donation 5 ☐ Other (Specify) 2/23/04 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexanders, Pope Funeral Homes AVA J. MIKELL per DVR 5538 Marlboro Pike, Forestville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of) Examiner IMMUNE COMPROMISE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed HIV Due to (or as a consequence of) anding physician a use as the burial-P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ō Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ EXTREMITY FRACTURES 1 Yes 2 No 3 Probably 4 Xunknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy rector, page performed? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 ☐ No 늉 this 28b. Time of Injury funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury IZ-210-1030ay Yeer) 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. P_{\bullet}^{M} 1 ☐ Yes 2 ☐ No investigation 7:04 Pedestrian struck by auto 2 XAccident after death Director: A 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Route 4 and Donnell Drive Forestville, MD 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide within 24 hours are To the Funerel Di Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/26/2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Will 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day Year Beverly Ann Stofan 4_ March 2004 5:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 90 Monroe Street Apt. 701 Rockville Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthptace (State or Foreign Country) 1 □ M 2 🗓 F 225-90-4700 47 Director Yrs. June 8,1956 Virginia Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location "neturel", or items 23s or 28s-f show sulcal Examiner must be notified at 10d. Inside City Limits MD Montgomery Rockville Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 90 Monroe Street Apt. 20850 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Peges 1 and 2 should be filed within 72 hours effer or Department of Heelth end Mentel Hygiene. Importent: if tem 27 is marked other then "naturelf, or iter eny injury or other treumatic event, the Medical Examine and injury or other treumatic event, the Medical Examine and injury or other treumatic event. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Medical Technologist of Health years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael J. Stofan ٥ Dolores Donodea 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine S. Ball/Sister 204 Yale Dr. Winchester, VA 20b. Place of Disposition (Name of cometery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Fairfax Mem. Park March9,2004 Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) Pair Facility Fair Fax Mem. Funeral Home 2902 Braddock Rd Fair fax, VA 22032 21. Signature of Funeral Service Licensee Richard 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician**)UARIAN ancor /Medical Due to (or as a consequence of): Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ettending physicien end for use es the buriel-trensit lew requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ ate hes been signi pege 2 should be Asthma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 40izenzaszy 39/14 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performed? Pain hronk 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ၉ 1 | Yes 2 | 1 | No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P s efter deeth. I Director: After d in by the funera 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Koh reman D37606 3-5-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Kohlerman 11904-F Darnestown Rd. Potomac, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 10 souks RANGEN Registrar

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND ITEM #5&24a PER FH &VERB G329Ceptificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:50 p 2004 Herby Semelfort March 13 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring or 1 Year | If Under 24 Hrs. Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 X M 2 □ F 44 589 -14 -9835 12-19-1959 <u>Haiti</u> Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No VA Fairfax Reston Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 2372 Antiqua Court 20191 USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. fited within 72 hours after Hyglene. 1 ☐ Yes 2 No 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 B1ack 3 ☐ Widowed 4 ☐ Divorced Year or Dates: natural Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 4 Finance Manager Automobile permit. Pages 1 end 2 should be filed 'Department of Health and Mental Hygic Important: If Item 27 is marked othar eny injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Louisa Brice 2 Hilairce Semelfort 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edna B. Semelfort - Wife 2372 Antiqua Court Reston, VA 20191 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 X Removal from State 3/20/2004 Southern Memorial Pk Miami, FL 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Adams-Green Funeral Home dans nm Elden St., Herndon, VA 20170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MYOCARIDAL INFARCTION Sudden /Medical Due to (or as a consequence of): **Examiner** DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit HYPERTENION and Due to (or as a consequence of): P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, à director, page 2 should be 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 □ Yes 💥 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 Yes 2X No 1 Inpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) the funeral 27. Menner of Death 1 CNatural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation M 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide TX Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0053528 March 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2309 Shorefield Road Daphna Henkin, MD Wheaton, MD 20902-1825 32. Registrar's Signature State Registrar

		State Registrar 1. Decedent's Name (First, Middle, Las	t)	Ce	rtificate of	Death	2. Date of Dea	leg. No. 20(3. Time of Death
sicia		T. Dooddon o Harris (7 not, Migglo, East	Sara	SA	ACK		Month	Day Yes	
edic imine		4a. Fecility Name (If not institution, give Suburban Hospita			4b. City, Town, o	or Location of Dea	March	4c. County of D Montgo	eeth
eral tor		5. Social Security Number 6. Security Number 155-05-9248	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		1923 R	Birthplace (State or Foreig Country)
		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	Į.	Maryland Montgom			Chase				1 ☐ Yes 2 汉No
	Director	10e. Street and Number 4701 Willard Ave	. #1125		10f. Zip Code	815		Og. Citizen of What	•
	Funerai	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	Hispanic Origin? (Specify Yes or No- into Rican, etc.)		merican Indian,
	۾	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:		1 ☐ Yes 2 ☐ No		ino Rican, etc.)	Specify:	white, etc.
	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of we	orking	16b. Kind of Busine	ss/industry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire rement A	d)		Medical S	Sunnlies
	ပ္ပ	17. Father's Name (First, Middle, Last)		11000	T Cili Cil Ci		ame (First, Middle,		Jappiles
	To Be	Karl Cu	tler			Rose	(unknown	1)	
Suce.		19a. Informant's Name/Relationship (7) Freda Goldberg, Da		19b. Mailii 8399 <i>A</i>	ng Address <i>(Street</i> A Montgom	and Number or F ery Run	Rural Route Number Rd., Elli	City or Town, State	e. Zip Code) 7, MD 21043
		20a. Method of Disposition 1 □ Rurial 2 □ Cremation 3 □		Place of Dispo cemetery, crei	osition (Name of matory or other pla	ce) 03/	19/04	20c. Location - City	or Town, State
		`4 ☐Donation 5 ☐ Other (Specify	, Kir		ld Memori	al Garde	•	Falls Chu	rch, VA
in it		21. Signature of Funeral Service Licen		Tr.	2. Name and Addre	II a har are	Funeral H	lome, Inc.	
^		23a. Part1. Enter the disease, or companies to the disease to t	olications that caused the deat	h Do not an	4 Carrol	1 St. N	W. Washir	gton, BC	20012 Approximate
A		shock, of heart failure. List only of Immediate Cause (Final			tor the mode of dyn	ng, scori as carere	ac or respiratory arr	200	Onset and Death
		disease or condition resulting in death)	a. Sepsis Due to (or as a consec	uence of):					6 weeks
ı			Ruptured Vi						6 weeks
۱	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						
	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C						
	cal E		Due to (or as a consec	dence or):					
			d						
	n/Me	IF FEMALE: 23b. Wes decedent pregnant	23c. If yes, outcome of pregna		75			23d. Date of	delivery
	Physician/Med	in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown		□Ectopic pregnanc □ Other (specify)	у		Month	Day Year
	/ Ph	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.	23e. Did to	pacco use contribute	to the cause of death?
	d by	Renal Failure					1□ Y	es 2 [X]No 3 [Probably 4 Unknow
	Completed	Coronary Artery	Disease				24a. Was a	n 24b. Were	autopsy findings availabl
	mo.						autops perfori 1 Yes	ned? death	to completion of cause of ? 'es 2 \sum No
	Bec	25. Was case referred to medical examiner?			-	26. Place of De	eath (Check only or		
-	To	1 ☐ Yes 2 € No	Hospital: 1 pnpatient 2	ER/Outpatier		4 🗆 Nursing	Home 5 ☐ Reside	ence 6 Other (S	pecify)
1	ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time o Injury	Wor	ry at rk? Yes 2 □ No	28d. Describe h	ow injury occurred	
1		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str y)	reet, factory, office		28f. Location (S. City or Town		Rural Route Number,
1	ertifi		ysician: To the best of my kno	wledge, deat	h occurred at the till vestigation, in my o	me, date and place opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner ate and place, and c	as stated. fue to the cause(s)
1	dical Certification;	29a. Certifier (Check only one) Certifying Physical Example)	iner: On the basis of examina						
1	Medical Certifi	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.		29c. Licens	se number	2	9d. Date signed (Mo	onth, Day, Year)
	edicai	(Check only 2 Medical Examone)	iner: On the basis of examina	¬		7147	2	9d. Date signed (Mo 03/17/04	**
	edicai	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	7	DO	7147	2	•	**

State of Maryland / Department of Health and Mental Hygiene 2004 State
Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year MARY T. SCHREIBER MARCH 16, 2004 1:04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROCKVILLE HEBREW HOME OF GREATER WASHINGTON MONTGOMERY If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F 577-48-7185 **Director** 1918 MASSACHUSETTS Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND MONTGOMERY BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 7907 MARYKNOLL AVENUE 20817 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 Ie marked other than any injury or other traumatic event, tra Ma College (1-4or 5+) 5+ Elementary/Secondary (0-12) LIBRARIAN COUNTY SCHOOL SYSTEM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERNEST BEAN LILLIAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY M. SCHREIBER/HUSBAND 7907 MARYKNOLL AVE., BETHESDA, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CREMATORY 03/21/2004 FALLS CHURCH, VIRGINIA 21. Signature of Funeral Service Licensee DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 INC. 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HLZHEIMER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 pronths?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 X No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has ormed? 1 ☐ Yes 2 ☐ No Vital 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 3 DOA of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division To the Hospitel or Attending 1 Natural 5 Pending investigation lnjury death. 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined tomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and Me completed cause of death (Item 23a) (Type, Print) 612 M-D. 31. Date filed (Month, Day 32. Registrar's Signature State Energy Registrar

			1 = For State Registrar	State o	f Marylar				ealth a Death			giene Reg. No	7 H I) 4	09994
	Dhunini		1. Decedent's Name (First, Middle	, Last)				_			2. Date of De	Da	v Y	eer	3. Time of Death
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Ž.	Examin	er	4a. Fecility Name (If not institution				-		Location of	of Death			. County of		
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land	Aental rked ric ev	To B	William Stamm						Ma	ry F	ulmer				
a	es 1 and 2 should be fi of Heeith and Mental I- f Item 27 is marked ot ir other traumatic ever	1 12	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Addre	ss (Street a	ind Numbe	r or Rura	I Route Numbe	er, City	or Town, Sta	ate, Zip	Code)
≥ ()	and m 27 her tr		Debra J. Horre	11/ Daugh		19844 Place of Dispo			Court		ntgomery		_*		md 20886
و	if it it		20a. Method of Disposition 1 X Burial 2 ☐ Cremation		State Wol	emetery, cre te s Cr	matory or OSS	other place Roads	9) M	larch	22,		ocation - Cit		
saltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ot		* 4 □ Donation 5 □ Other (S _I) 21. Signature of Funeral Service I		1	Cemet		nd Addres	s of Facilit	2004					nsylvania
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ğ	w require been sig should b		Hypertension,	Coronary	Artery	Disea	ıse,				1 🗆 1	Yes 2	□ No 3[] Proba	ably 4 X Unknown
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	_		30. Name and address of person v						7	- 36					
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			For State Registrar	State	of Maryla		epartmei Certifica					giene Reg. No	2001	00005
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	Examin		4a. Facility Name (If not institution				4b. City	, Town, or	Location of				County of Dea	ith
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	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🔼 F		rs. last birtho Yr	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da Nov. 28	th y, Year) 1 O '	9. Bii C 2.7 A.r.l.	rthplace (State or Foreign ountry) Cansas
	Director		432-38-0159 Usual Residence of Decedent		/	0		1		·	NOV . 20	, 192	Z/ AIF	cansas
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	fter d	Fun	1 ☐ Never Married 2 ☐ Marri	ied 1 ☐ Ye	Forces? s 2 🔂 No	10.0.	If Yes, spe	ecify Cuba	n, Mexican	n, Puerto F	Rican, etc.)		Black, Whi	te, etc.
3	al', o	þ	3 Midowed 4 Divorced	If Yes,	Give r Dates:		1 🗆 Yes	2⊠ No	Specify:			'	Specify: Wh	1te
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	s 1 and 2 should be filed within 72 hours after death with the Maryla if Heathth and Mental Hygiene. It is terms 23a or 28a-1 ahov citem 27 is marked other than "natural", or Itams 23a or 28a-1 ahov other traumatic event, Ita Madical Exama as Irusal be rivitlied at	To Be	Crafton Con	,							Bonner		,	
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9	1		30. Name and address of person	who completed ca	ause of death (i		pe, Print)			, _		* /		20910
			DR. ROSITE 31. Date filed (Month, Day, Year)	1 DE	E Parintenala Ci	883	O CI	9ME	RON	5	t. E	01/16	R-SPA	RING Md.
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Н	Physici		Veronica Alberta	Smith				March 14	Day 2004	8:09 A M
	/Medio Examir		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Death	
			Prince George's Co	mmunity Hospit	al	Chever1y	7		Prince Ge	orge's
1.5	Funeral Director		310-11-2202	7. Age (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Aug • Ib	(ear) 9. Birthr Cour Wash	plece (State or Foreign http) nington, DC
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. City, 1	own or Lo	cation				10d. Inside City Limits
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	ns 23	Funeral		12. Was Decedent Ever in U.S.	13. 1	20706 Was Decedent of Hi	spanic Origin? (Sp		Inited Stat	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show minuty or other traumatic event, the Medical Examinar must be notified at ODGs.		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2X No		Rican, etc.)	Black, White, Specify: Bla	
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re,	f Hea item	1	20a. Method of Disposition	20b. Plac		sition (Name of natory or other place		and the same of th	Dc. Location - City or To	own, State
Ë	Page nent o nrt: If		1 ABurial 2 □ Cremation 3 □ R *4 □ Donation 5 □ Other (Specify)	emoval from State		Cemetery		/04 W	ashington,	D.C.
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ita		a	25. Was case referred to medical				26. Place of Death	1 Yes 2	No 1 □ Yes	20 NO
_	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🕱 No	ospital: 1 ☑ Inpatient 2 ☐ ER	/Outpatien	t 3 DOA Othe	or: 4 Nursing Ho	me 5 Residenc	ce 6 □Other (Specif	y)
0	ing Pl Viter ti unera		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury Work	?	28d. Describe how	injury occurred	
sio	Attending it death. ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	OPa Diesa of Injury At home			/es 2□No	Opt Leasting (Ctr.		70 444
Division of	tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director,	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, rarm, str	eet, factory, office		City or Town,	et and Number or Rura State)	l Houte Number,
	To the Hospital or Att within 24 hours after d to the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my knowle ter: On the basis of examination and manner stated.	dge, death and/or inv	n occurred at the tim vestigation, in my op	e, date and place, inion, death occurr	and due to the cau ed at the time, date	se(s) and manner as si e and place, and due to	ated. the cause(s)
	To the I within 2	Σ	29b. Signature and title of certifier	08 10		29c. License	,		I. Date signed (Month,	Day, Year)
,	24)	Dalch Do	se M.D.		Dec	32761		117/04	
	10		30. Name and address of person who co	mpleted cause of death (Item 23 M.O - 9470-AN	na P	Print)	#418	Lanhan	m MO. 9	0706
1	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	6	Anna Va	/			

			For State Registrar	State of N	Maryland / Depa	artment of H			giene Reg. No. 2	004	naga.
e e e e e e e e e e e e e e e e e e e	Physic		Decedent's Name (First, Middle John P. Soden	, Last)				2. Date of De Month	aath Day	Year	3. Time of Death
	/Medi Examii		4a. Facility Name (If not institution,		r)	·	r Location of Death	3-12-0	4c. County	of Death	3:00 A. M
	Funeral Director		066-16-5651		Age (In yrs. last birthday)	Silver S If Under 1 Year Months Days	Pring If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 8-5-21	th i <i>y, Year)</i>	9. Birthplac Country, NY	e (State or Foreign
	e Maryland ta-f show	ctor	Usual Residence of Decedent	mery	10c. City, Town or Lo					10d.	Inside City Limits
	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23e or 28e-f show event. The Mcdirel Exeminer must be notified at	Funeral Director	10e. Street and Number 14124 Ansted Rd 11. Marital Status	12. Was Deceder	nt Ever in U.S. 13.	10f. Zip Code 20905 Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (St	Decify Yes or No	U.S.A.	What Country ce - American	Indian,
21215-0036	72 hours afte natural', or II	by	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced 15. Decedent (Specify only highes)	If Yes, Give Year or Dates s Education	No II III III III III III III III III III	1 ☐ Yes 2 ☑ No dent's Usual Occupa kind of work done of	Specify:			w White	e
d 2121	filled Hygi other	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, L	College (1-4o	r 5+) life.	of Perso)		Dept. (ıs.
Maryland	2 should be and Mental Is marked (aumatic ev	To B	Bernard Soden 19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailir	ng Address (Street a		et Galla		State, Zip Co	ode)
	1 and 1ealth em 27 ther tr		James B. Soden 20a. Method of Disposition 1 Structure 2 Cremation		20b. Place of Dispo	4 Ansted	Rd. Silv			20905	
Baltimore,	permit. Pages Department of H Important: If Ite any injury or of		4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L	ecify)	Gate of	. Name and Addres	s of Facility Hi:		aldi F.	н.	MD 20904
8760,	death certificate be executed By Age attending physician and a for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	a. Corona Due to (or a b. Acute Due to (or a Sepsis	ed the death. Do not ent line. ry Heart Di: s a consequence of): Renal Failu: s a consequence of): s a consequence of):	sease	g, such as cardiac	or respiratory ar	rest,	int Or y	proximate erval Between sset and Death ears
.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of delivery nth Day	y Year
ords, P.	requires een sign	by	Part II. Other significant condition congestive heart		but not resulting in the ur	nderlying cause give	on in Part I.		obacco use contr		ause of death?
of Vital Record	The la ate has page 2	e Completed	25. Was case referred to medical				26. Place of Deat	1 ☑ Yes	rmed? c 2 □ No 1	Vere autopsy prior to complete the complete that he compl	findings available ation of cause of
Division of V	ding Phys n. After this funeral di	Certification; To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	28a. Date of In (Month, D	ient 2 ER/Outpatien jury 28b. Time of lnjury	28c. Injury Work	r: 4 ☐ Nursing Ho	me 5 Resid	lence 6 Othe		
Divi	ital or Attensus after deatl		4 Homicide determin	ned 28e. Place of If building, e	njury - At home, farm, stre etc. (Specify)			City or Tow			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	t of my knowledge, death of examination and/or inv taged.	estigation, in my op	inion, death occurr	ed at the time, o	date and place, a	and due to the	cause(s)
	(D	~	29b. Signature and title of certifier 200 5:5 30. Na in address of person w	tho complete se of	death (Item 23a) (Type, I	29c. License	808		3/1	(Month, Day,	Year)
14	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 5	32. Regis	trar's Signature	Sparks	13 Geel	919 1	1 A 7 L	TVEV SJ	my my

Physician Content Name (First, Middle, Last) Content of Death				1 - State Registrar	State of Man	land / Dep. <i>Ce</i>	artment <i>rtificate</i>	of Health of Dea	n and N th		giene 2	004	09998
Terranter Foreign F						11				2. Date of Dea	ath	0 64	3. Time of Death 3:40p м
Under Personal Purpose of Description of Descriptio			_			me	1				•		
To State The property Theproperty The property The property The property The prope				451-54-5993	M 2187 F					8. Date of Birt (Month, Day 10/27	/ Year) /1914	Cou	ntry)
T. Father's Name (First, Middle, Last) Jack E. A. Bell Betty Beatrice Cross State Beatrice Cross State Beatrice Cro		Maryland	tor	10a. State 10b. County									10d. Inside City Limits 1 ☐ Yes 2 ₹ No
17. Father's Name (First, Middle, Last) 19. Mother's Name (First, Mi		th with the 23s or 28	al Direc		nue								ntry?
T. Father's Name (First, Middle, Last) Jack E. A. Bell Betty Beatrice Cross State Beatrice Cross State Beatrice Cro	9800	ours after dea rral', or Itams Examinar m	d by Funer	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		If Yes, specify	Cuban, Mexi	can, Puerto	ecify Yes or No- Rican, etc.)	Bla	ack, White,	etc.
Dack F.A. Bell Setting Cross Land Setting Cro	21215-0	within 72 h iene. r then "natu I're Medical	ompleted	(Specify only highest grade	College (1-4or 5+)	(Give	kind of work DO NOT use	done during n retired)	ost of work	ing			,
20. Memoral of Disposition 1 Disposition 1 Disposition 1 Disposition 1 Disposition 2 Disposition 1 Disposition 2 Disposition 1 Disposition 3 Removal from State	yland 2		Be				1000	18. Mc			Maiden Suma	me)	_
Disputation Coloration Co		1 and 2 Health a Sm 27 I		Victor Steckol 20a. Method of Disposition	1/Son	1361 20b. Place of Dispo	3 Aqu	a Lan	e Ro	ckville	e,Md 2	0850	
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval serveen. Criteria and course (Final resulting) in death) Physician (Micelical Examiner) Physician (Mi	Baltimo	0 0		* 4 ☐ Donation 5 ☐ Other (Specify)		Memoria 22	al Pa: PHILIP	rk Cer Address of Fa D.RI	cility NALD	I FUNE	RAL SE	RVIC	E,P.A.
The part of the pa		/Medical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	death. Do not ent	ter the mode	of dying, such	as cardiac	or respiratory ari	rest,		Approximate Interval Between
25. Place of Death Check on one 26. Place of Death Check on one 27. Manner of Death 1 Normal Source 28. Describe how injury occurred 29. Describe how injury occurred 29. Describe how injury occurred 29. Describe how injury occurred 29.	8760,	ate be executed hysicien and the burial-transit	licai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·								
25. Place of Death Check on one 26. Place of Death Check on one 27. Manner of Death 1 Normal Source 28. Describe how injury occurred 29. Describe how injury occurred 29. Describe how injury occurred 29. Describe how injury occurred 29.	Box 6	the death certific y the attending p iched for use as	ysician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim	Fetal death 3							
25. Place of Death Check on one 26. Place of Death Check on one 27. Manner of Death 1 Normal Source 28. Describe how injury occurred 29. Describe how injury occurred 29. Describe how injury occurred 29. Describe how injury occurred 29.	rds, P	quires that in signed b uld be deta	by	Page II. Other significant conditions cor DEMENTA	tributing to death but n	ot resulting in the u	nderlying cau	se given in Pa	rt I.		_		
The state of the s	al Reco			STROKE						autops	med?	prior to con death?	mpletion of cause of
The state of the s	Zi.	siciar certif recto	00	examiner?	lospital:			0.					A Dillion W.
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Segistrar's Signature	of	th. : After this stuneral di	\vdash	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury	28b. Time of	f 28c	Injury at Work?					v)
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filled (Month, Day, Year) 32. Segistrar's Signature	Divis	s after des s firector af Director	Certifica	determined	28e. Place of Injury building, etc. (S	At home, farm, str Specify)	eet, factory, o	ffice				ber or Rura	l Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Anne Wilson MD 14812 Physicians Lane #162 Rockville, Md State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		the Hospi in 24 hour the Funer pletely fills	edical	(Check only 2 Medical Examination)	ner: On the basis of exa	y knowledge, death amination and/or in	n occurred at vestigation, in	the time, date my opinion, d	and place, a	and due to the c ed at the time, d	ause(s) and m ate and place,	anner as st and due to	ated. the cause(s)
Dr. Anne Wilson MD 14812 Physicians Lane #162 Rockville, Md State 31. Date filed (Month, Day, Year) 32. Begistrar's Signature		To T Com	Σ	29b. Signature and title of certifier	- mc		_			2			
The state of the same of the same of the state of the same of the	022	Str	te.	Dr.Anne Wilson 31. Date filed (Month, Day, Year)	1 MD 1481	12 Physi	Print) LCians	Lane	#1	62 Roc	kville	,Md	

			For State Registrar	State	e of Mar	ryland / De _l <i>Ce</i>	oartmer e <i>rtificat</i>	t of H	ealth a Death	and M	ental Hyg	jiene	20)4	09999
₩ ₁	* * 1.		Decedent's Name (First, Middle,	Last)							2. Date of Dea Month		. Va	ar	3. Time of Death
. Davi	Physicia /Medic		Ingeborg Kaun	Swarm							March 1		2004	, a	10:36 A ^M
	Examin		4a. Facility Name (If not institution,	give street an	d number)		4b. City,	Town, or	Location o	of Death		4c.	County of [eath	
7			14812 Claude I		-	(1 t + t- t- t- t t t- t- t- t- t- t- t-) lé l la da	Silv riyear	er Sp				Mont		
	Funeral			6. Sex 1 ☐ M 2 🔀	-	(In yrs. last birthda Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	, Year)		Count	
	Director		218-56-6821 Usual Residence of Decedent		<u> </u>	88					Jul 30,	19	15 (jern	nany
	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-f show ha Madical Extratrer and be neithed at		10a. State 10b. County			10c. City, Town or	Location							10	d. Inside City Limits
	ath with the Marylan 23a or 28e-f show	ctor	Maryland Mont	gomery		Silver	Spring								1 ☐ Yes 2X No
	or 28	Directo	10e. Street and Number				10f. Zip	Code			1	0g. Citi	zen of Wha	t Count	ry?
	23a		14812 Claude I	'n	,			2090					USA		
	r des	Funerai	11. Marital Status	Arme	Decedent Eved Forces?		 Was Dece If Yes, spe 	dent of Hi cify Cubai	ispanic Orig n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		14. Race - / Black, V		
36	s afte	by Fi	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Ye	Yes 2∭X No s, Give or Dates:	'	1 🗆 Yes	2 X No	Specify:			į	Specify:	T.	Thite
8	tural tural	pa	15. Decedent		OI Dates.	16a Dec	edent's Usu	al Occupa	ation		1	16b Kii	nd of Busin		
5	in 72 in 6	Completed	(Specify only highest	grade comple		(Gi	o kind of wo	rk done a	during most	t of workir	ng				,
212	with jiene.	шо	Elementary/Secondary (0-12)	Colle	ge (1-4or 5+) 4	'	Homema	ker					Own	n Ho	ome
ğ	I Hygi other	0	17. Father's Name (First, Middle, L	ast)					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)		
Maryland 21215-0036	Mental rked o	To B	Eugen Kaun						E1i	zabe	th Gotz				
ary	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items any injury oc other traumatic event, Ita Modell Extra	g 11	19a. Informant's Name/Relationsh	ip <i>(Туре, Print</i>)	19b. Ma	iling Address	(Street a	and Numbe	r or Rura	l Route Number	r, City o	r Town, Sta	te, Zip (Code)
	and 2 salth n 27 I		William E. Swa	arm/Son							VA 221				
altimore,	of He		20a. Method of Disposition 1 Darial 2 Commation	3 □Bemoval t	from State	20b. Place of Dis	position (Na rematory or c	me of other place	θ)	D	ate	20c. Lo	cation - City	or Tov	vn, State
Ē	Pages ment of I ant: If its ury or o		*4 □Donation 5 □ Other (Sp			Loudon									
Balt	epart nport ny inj		21. Signature of Funeral Service L	icensee	4.						es-Rina				
_	<u>v</u> ∪ = ⊴ o		Iluane a	CAA	fille								er Spi	7	, MD 20904
£.			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications to only one cause	that caused the	3		/1				est,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Arti	ten-scle	rtic	fland	nt 1	718c	ere				Years
3 ¹ -1	/Medical Examiner		resulting in death)	Du	e to (or as a	consequence of):									
% - 33	g. Ant.	-	Sequentially list conditions if any, leading to immediate	b	manin asa	consequence of).								-	
	ped Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		.0 (0, 00 0	301133q331133 317.									
^	xecu al-tra	xar	that initiated events resulting in death) Last	c. Du	e to (or as a	consequence of):								177	
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit			d											
9	ificate g phy as the	Physician/Medical										- 1			
Вох	leath certifica attending ph i for use as th	N/	IF FEMALE: 23b. Was decedent pregnant		s, outcome of		B □Ectopic p	rennancy				2	23d. Date of		
	deatle atte	icia	in the past 12 months? 1 □ Yes 2 ⊠No	4 □ F	Pregnant at ti		Other (s						Month		Day Year
0	n requires that the death cer been signed by the attendir should be detached for use	hys	9 Unknown										_	_	
	es thi gned be de	by F	Part II. Other significant condition	ns contributing	to death but	not resulting in the	underlying (ause give	en in Part I.			_			cause of death?
ord ord	equir sen s	ted	yncontenent	-e		1 /	1				1 🗆 Y	es 201	Z(N)0 3[Proba	bly 4 □Unknown
ec	e lawr has be je 2 sh	Completed	Frequent (1514 ans	free	* unfie	ens	<u> </u>			24a. Was a autops	sy	prior	to com	sy findings available pletion of cause of
<u>ح</u>	The page	Con		,							perform 1 Tes	med? 200 No	deat	h? Yes 2	2 □ No
/ita	Attending Physicien: Thirdeath. cdeath. sctor: Atter this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho	26		(Check only or	10)			
of	Physi this c	۴	1 ☐ Yes 2(D No 27. Manner of Death		1 Inpatient				4 LI NU	rsing Hon	ne 5 Reside		Other (Specify)	
Division of Vital Records,	ding I	Certification:	Watural 5 ☐ Pending	1	(Month, Day	Year) Zoo. Time	, м	28c. Injury Work	γαι ⟨? Yes 2 □ ľ		.ou. Describe no	ow mjur	y occurred		
<u>S</u>	death death ctor: / the	lcat	2 Accident investig 3 Suicide 6 Could n	ot be	Place of Injur	y - At home, farm,					28f. Location (S	treet and	d Number o	r Rurai	Route Number,
<u>≥</u>	for A after Direction by	ertil	4 ☐ Homicide determi		building, etc.			,,			City or Tow	n, State,)		
_	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier V Certifying	Physician: T	o the best of	my knowledge, de	ath occurred	at the tim	ne, date and	d place, a	and due to the c	ause(s)	and manne	r as sta	ted.
	e Ho 124 h 16 Fui letely	edical	(Check only 2 Medical E		the basis of e manner state	examination and/or ed.	investigation	i, in my op	oinion, deat	th occurre	ed at the time, d	ate and	place, and	due to t	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	1,6			29	c. License			2	9d. Dat	e signed (N	lonth, D	lay, Year)
	10		/ ne /-	- 12		200	2	03	3333	ナナ		1	1aro	h 1	1,2004
	10		30. Name and address of person v	yho completed	cause of dea				-		1			,	1,2004 hen, MD
_			Lee Jonall	ian p	1 vs h-	ec un	55.	se l	NISC	Dn s	n Ave		hem	101	ren, MD
	Sta		31. Date filed (Month, Day, Year)	2004	32. Registrar	- /.	1.	0.10	,				1		,
1	Regist	ar	MAKI	4004	proper	1	ap	alls							

		1 - State Registrar	State of Maryla		rtificate o			Reg. No. 2	10000
Physicia	an	Decedent's Name (First, Middle, Last	_				2 Date of De	aath	3. Time of Death
/Medic		Albert 4a. Facility Name (If not institution, give					Marc		2004 205 AM
Examin	er	Shady Grove Adver		1		n, or Location of kville	r Death	4c. County	
uneral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday)	If Under 1 Ye	ar If Under 2			1tgomery 9. Birthplace (State or Foreign
rector		203-20-4307	X ^{M 2 □ F} 84	Yrs.	Months Day	ys Hours		ау, Year) 8 , 1920	Birthplace (State or Foreign Country) China
6237		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	reation				
atic event, the Medical Examinar must be multiled at	ō	Maryland Montgo		Rockvil					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
Distriction	rect	10e. Street and Number	iner y	ROCKVII	10f. Zip Code	Ð		10g. Citizen of V	
100	Funeral Director	1842 Greenplace	Terrace		20850	0		U.S.A.	-
	Iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of	of Hispanic Orig	gin? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac	e - American Indian,
	by Fu	1 ☐ Never Married 2 Married	1 XIYes 2 □ No Wo	rld	1 ☐ Yes 2 🂢 N		, ruento rilcan, etc.)	Specify	ck, White, etc.
	a pa	3 Widowed 4 Divorced	Year or Dates: War	II					Chinese
	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during most ired)	of working		usiness/Industry
	mo	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		onomist			Intern Serv	al Revenue
ļ	BeC	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middle,		
	일	T.Y. Sze				G	ing Hong Y	ee	
		19a. Informant's Name/Relationship (7		19b. Mailir	g Address (Stre	et and Number	or Rural Route Number	er, City or Town,	State, Zip Code)
1		John L. Sze -sor		1254	3 Carrin	ngton H	ill Dr., Ga	aithersb	urg, MD 20878
0		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Homovai ilomi otate		sition (Name of natory or other p	1.0	Date / 1.6 / 2.0 0 /	20c. Location -	City or Town, State
DUCE. C		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen: 			rt Crem	acci j	/16/2004		dria, VA
Duce		21. Signature of Funeral Service Licen:	1/12	1206	. Name and Add	fress of Facility	Joseph Gaw	ler's So	ns, Inc.
		23a. Part1. Enter the disease, or comp		1296 5	IJU W1SO	consin A	Ave. NW, Wa	ashingto	
	1	shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	201. 00 1100 0110	ar the mode of d	yrig, such as c	ardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
n il		disease or condition resulting in death)	a. USPIrati	on f	meum	onia			days
r	Ì			querice or).					
	ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to (or as a conse	பும்சாசே ut):					
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	¢.						
		resulting in death/ East	Due to (or as a conse	quence of):					
	dicai		d						
	√Me	IF FEMALE:	23c. If yes, outcome of pregr	ancv					
1	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3	Ectopic pregnan Other (specify)	су		23d. Date Mon	of delivery oth Day Year
	hys	9 Unknown	9□ Unknown		- III (() p = 0 III)				
1	ру Р	Part II. Other significant conditions co		sulting in the ur	derlying cause g	oven in Part I.	23e. Did to	bacco use contri	bute to the cause of death?
j	ed	chronic lympi	rocytic 1	ecker	nia		1 🗆 Y	es 2000	3 Probably 4 Unknown
1	ompieted						24a. Was a		Vere autopsy findings available
	Con						— autop perfor 1 ☐ Yes	med? de	rior to completion of cause of eath? □ Yes _2⊠No
- 1	Be	25. Was case referred to medical examiner?				26. Place o	of Death (Check only or		165 24 110
Ш.	ို	1 ☐ Yes 2 No		ER/Outpatien	3□ DOA O	ther: 4 🗆 Nurs	ing Home 5 Resid	ence 6 Othe	r (Specify)
	ii o	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju			ow injury occurre	
	icat	2 Accident investigation 3 Suicide 6 Could not be	00 50			Yes 2□No			
1	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre fy)	et, factory, office	•	28f. Location (S City or Town	treet and Numbe n, State)	r or Rural Route Number,
		29a. Certifier Phy	sician: To the heet of my len	Owledge death	Annuerod of the	time data :	elene er did i i i i		
	edical	(Check only 2 Medical Exami	sician: To the best of my knoner: On the basis of examinating and manner stated.	ation and/or inv	estigation, in my	opinion, death	piace, and due to the c occurred at the time, d	ause(s) and man late and place, ar	ner as stated. nd due to the cause(s)
		29b. Signature and title of certifier			29c. Licen	ise number	2	29d. Date signed	(Month, Day, Year)
		Alicia	1. Mistry	MD	De	5972		_	
	-	1,000	ompleted cause of death-(ter	n 23a) (Type, F	Print)	- 1 1 - 2		CAL	16,200
	-	So. Manie allo address of person will o							
		Alicia Mistr 31. Date filed (Month, Day, Year)	4 9901 M	edica	cent	er Dr	ive Roc	kville,	12,2004 MU 20850